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MARRIAGE, MORALS AND  
MEDICAL ETHICS

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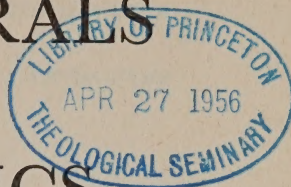
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*and*  
MEDICAL ETHICS



BY

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*Censor Deputatus*

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*June 20, 1951*

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PRINTED IN THE UNITED STATES OF AMERICA



*To the Sacred Memory of Our Parents  
Whose Fidelity to the Principles  
We Uphold Here  
Made Us and Our Work Possible,  
We Dedicate This Book*





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## FOREWORD

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AT ALL TIMES morality has been the law of human life and honor and the guarantee of civilization. It is only because of morality that men can live with each other in brotherhood and with love and justice towards every man. It is only because of morality that men respect and obey the edicts of lawful authority and the rights of all nations. For morality gives men the fundamental and indispensable principles whereby they are able to walk the earth true to their dignity and destiny and because of which they respect the rights of God, man, and the state. Moral principles have their root in the divine wisdom manifested in nature and revealed in the words of the Old and New Testament. This divine wisdom is their guarantee of infallible rectitude. From which it follows necessarily that man's actions and teachings must be erroneous, deceitful, and inevitably ruinous if at variance with the wisdom of an Almighty and All Wise God.

In recent times, in fact for years now, there has been a continuing break with the moral law which has nurtured

and made Christian civilization strong. Unfortunately, too many minds, captivated by man's advance in the measurement of nature and its forces, have become utterly blind to their own ignorance of the true essence and qualities of creation and of the Creator Who is the cause and the end of each and every being living or not living. Swept on by a feeling of triumph, they have proclaimed themselves as modern gods and deposed the true God and His wisdom. They have poured out their thoughts in words and have adversely influenced countless millions. These teachers ask that man cast aside the Christian norms of conduct which alone recognize man's true dignity and direct him to his true destiny. They ask man to live on the bread of utility and adaptation to his environment and lose his spirit by which he is distinguished from the beast and for which the Son of God died that it may be eternally happy. They preach the death of an unwavering code of conduct governing the every action of man and leave him at the mercy of his whims, fancies, emotions, prejudices, and individual personal goals. Blind to fallacy and error in their tenets, they do not and cannot see that they are the real source of the infection which has swept the world to weaken the inalienable dignity and rights of men and nations. Their teachings have filled the world with moral morons in splendid halls and lowly slums. In unctuous phrases they have cast out God and His law, which alone gives meaning to life and is the true bread of man. In exchange they have offered to man the serpent of secularism and the stones of agnosticism, pragmatism, and totalitarianism.

Nearly every field of human endeavor has felt the im-



pact of these baleful influences, and the science of medicine is not an exception. It is a science which has been among the last to become tainted by these errors. But tainted it has become. For what can one say, when one dedicated to the preservation of life and limb advocates euthanasia, unjust sterilization, and therapeutic abortion as moral solutions to various problems, other than that not only has Christianity been forgotten by such a one, but even the literal meaning of the Hippocratic oath has gone into oblivion? We even find, among this truly esteemed profession, some who are proud to lend their aid to the solution of emotional, economic, and social ills by promoting the perversion of contraception, artificial insemination, and conscienceless experimentation. Can such be called Christians or even upholders of the natural moral law?

The authors of this book, one, Dr. Frederick L. Good, an eminent physician and authority in his field, and the other Reverend Otis F. Kelly, also a physician of evident skill and experience and now a priest, have once more proved the compatibility of true science with Faith and morals. They have in a clear fashion shown that God's law is no handicap to the accurate and successful treatment of medical problems which at times beset the doctor in his treatment of patients.

Forcefully, candidly, scientifically, and ethically the authors bring God back to the bedside of the ill. They have shown that God must be kept before the eyes of doctor and patient and that His wisdom and judgment should guide both regardless of the problem. Adequately

they have shown that moral principles also have their part to play in the field of medicine to the benefit of doctor and patient. They have truly demonstrated that a healthy mind and body can be truly healthy only when God is firmly embedded in the heart and mind of man. It is my devout hope that God will bless the authors and all those who may read this work.

✠ RICHARD J. CUSHING  
*Archbishop of Boston*

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## AUTHORS' NOTE

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**T**HIS WORK is a discussion of medico-moral problems in matrimony confronting priests, physicians, nurses, social workers, hospital administrators, and all those who need responsible information. It is based on the long experience of the authors, and they have attempted to express themselves in a language that can be understood by the uninitiated in regard to medical matters and by the physician in regard to theology.





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## CHAPTER ONE

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# THE CHRISTIAN CONCEPT OF MATRIMONY

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IN ORDER to appreciate intelligently the opinions set forth in this book, it is necessary first to know the fundamental principles upon which they are based. Therefore, we propose in this chapter to give a concise statement of these fundamental principles for the benefit of those readers who may not know them and to mention some of the safeguards set up by the Church for their maintenance.

The Christian concept of matrimony is in almost direct opposition to the decadent concept which was prevalent in the world at the time of Christ and which is again prevalent in the world today. This is evident to anyone acquainted with the widespread practices of easy divorce, contraception, sterilization, and abortion for the slightest medical, economic, or "social" indication, as well as the childless marriages and families with one or very few children as a result of careful planning.

In the concept of matrimony which accompanies wide-

spread deterioration of morals, marriage is a contract which is temporary and can be terminated at the will of one or both of the contracting parties. Therefore, this concept makes divorce easy and leads to the neglect of children. It makes sexual satisfaction, social or economic status, or domestic servitude the primary purpose of marriage and sanctions the prevention and destruction of children if they stand in the way of the health or comfort of the parties. Paganism makes the State supreme (the "totalitarian state" of today) and, therefore, gives the government the power to dictate the regulation of conception and birth and the kind of education and training to be given children. True, in some of the great pagan cultures, during the brief periods of their real greatness, there were those who worshipped the household gods and respected the permanency and sanctity of the family; but the masses, guided or swayed by the principles of paganism, lived for lust, power, or riches, and the decay of the family led to the decay of the state.

## THE NATURAL CONTRACT

Marriage is in the first place a natural contract and has been such since human life began. It is a contract entered into by one man and one woman, who differ from other animals in being intelligent and having some freedom of choice. It is a contract by which each agrees to give to the other certain rights, especially in matters of sexual union, but also in matters of mind and heart and material possessions. It is a contract by means of which a new society is formed, namely, the family, which is the



fundamental unit of all society. It has definite purposes, of which the first purpose is the generation and education of children, the second mutual help and consolation, and the third the lawful and reasonable enjoyment and satisfaction of the sexual appetite.

This natural contract is entered into for life and can be terminated normally only by the death of one of the parties to it. This follows from the purpose of the contract. The human offspring is the most helpless of animals, requires a tremendously longer period to mature than do other animals, and, in order to mature properly, requires the care of the parents and the stability of the home. By the time that the children who ordinarily are born in a wholesome family are mature, the parents are beyond the stage of being able to *establish* another family.

The evils which follow temporary unions in the so-called marriages of pagan culture are only too obvious to the observer and only too well proven in recent years by the investigations of social scientists.

## THE SACRAMENT

Among Christians, the contract of Matrimony is a sacrament. A sacrament is a sign, capable of being perceived through the senses, which has been instituted by Christ to give or increase Sanctifying Grace. In the case of Matrimony, the natural contract itself is the sign which Christ selected and to which he attached the power to confer upon the contracting parties sanctifying grace and those graces necessary to enable them properly to fulfill the re-

sponsibilities of their new state in life and properly to enjoy the benefits of it.<sup>1</sup>

Matrimony is the only state in life, except the priesthood, for which Christ instituted a sacrament. Therefore, for baptized persons the natural contract is also a sacrament, and the married state a sacramental state. It and the family are something more than merely natural. The parents owe to their children something more than mere support and education during the period of maturing. They also owe them training by example and instruction in those things that are necessary to attain their supernatural destiny. This will, perhaps, be better understood if we speak briefly about the meaning of the term supernatural and about the nature and destiny of man, both natural and supernatural.

Man, in addition to all the powers possessed by his fellow animals, for example, sense perception, memory, imagination, instinct, emotion, impulse, and the like has also the power to obtain knowledge of a nonmaterial kind by abstraction, judgment, and inference, as well as the power (though limited) to make free choices in deciding the course of his own life and in isolated acts. By exercising these powers he comes to the knowledge of the existence of God and some of His attributes. Since the natural destiny of any being is the exercise of his powers and the enjoyment of what he has gained by that exercise, man's natural destiny differs from that of his fellow animals in that it includes the knowledge, love, and service of God,

<sup>1</sup> Pius XI, Council of Trent. Sess. XXIV. Can. I: Code of Canon Law. Can. 1012, 1.

as a result of the exercise of his highest natural powers.<sup>2</sup>

In addition to being given a natural destiny, the Christian has been elevated by Baptism to a supernatural status and given a supernatural destiny. He is able to know by supernatural revelation and assistance more than he could ever learn by natural methods; he is able to give to his actions a supernatural value; he is destined not only to the natural knowledge of God which he has by reasoning and the supernatural knowledge which he has by revelation, both of which are indirect and clouded, but also to an eternal intimate knowledge of God and the enjoyment of His company as a reward for conforming himself to the Divine Law during this life.<sup>3</sup>

Now, a reasonable man or woman will always subordinate that which is less important to that which is more important. The reasonable man or woman not only controls his environment to some extent, but also controls himself. If he suffers from diabetes, he does only those things which will not interfere with his life's work and his health, and he will not endanger his life merely to satisfy a physical craving. He will act similarly in the case of other diseases. The reasonable Christian, knowing what his supernatural destiny is, will regulate all his conduct with a view to attaining that destiny. He will do only those things which are directed toward that end, or at least are consistent with it, and will refrain from conduct that will interfere with it or imperil it.

<sup>2</sup> St. Paul, Rom. I:20. "For the invisible things of Him, from the creation of the world, are clearly seen, being understood by the things that are made."

<sup>3</sup> St. Paul, I Cor. XIII:12. "I shall know even as I am known [by Him]."

It is obviously impossible for anyone fully to understand and appreciate the teaching of the Church in regard to marriage, divorce, birth control, sterilization, abortion, artificial insemination, and the like unless he knows this general Christian concept of human nature and destiny; and it is hardly to be expected that men and women who do not subscribe to these principles will face danger to health, to life, or to economic or social status in order to live up to them. Men are admired who risk health, life, or property to relieve suffering, to defend honor, or to guard the nation; and those who do not are considered selfish, dishonorable, or even traitorous. How much more worthy of sacrifice, when necessary, is the friendship of God and the attainment of one's eternal destiny. "What shall it profit a man if he gain the whole world, and suffer the loss of his soul?" <sup>4</sup>

#### NORMAL SEX LIFE IN MARRIAGE

The sex life in marriage, like all other things, is to be regulated in accordance with the fundamental principles of Christian life. In either merely natural marriage or in Christian marriage, the purely sexual life is a subordinate element, since the two persons blend their entire lives. It is an occasional climax in the expression of mutual affection and is subordinate to the more important union of purpose and work in the generation and education of children, which is the highest calling of husband and wife. Therefore, like all other things, it is to be enjoyed in mod-

<sup>4</sup> Christ, quoted in Mark VIII: 36.



eration and in the natural manner. Each is bound to have intercourse, (i.e., to perform the sexual act) when it is reasonably desired by the other unless serious reason exists for refusal. They may refrain from intercourse for any length of time by mutual consent. Any positive effort to enjoy it in an unnatural manner is contrary to Nature and, therefore, since Nature was made by God, is contrary to the designs of God. As a matter of fact, its unnatural character can be judged from its effects, since it is well known to those who are concerned with emotional disturbances and marital disagreements that the unnatural use of sex in marriage leads to mutual suspicion, coldness, and anxiety, and frequently to infidelity.

#### SANCTITY AND PURPOSES OF MARRIAGE

Matrimony, therefore, is in the real sense of the word a holy state and has been made more holy by Christ as a sacrament. Furthermore, in using the privileges of Matrimony, a man and a woman actually co-operate with God in the generation of individuals who are destined to be the adopted children of God. The human child, furthermore, requires care and training for a far longer period than the offspring of any other animal, and for a long time the human infant is utterly helpless in so far as procuring his own food or taking care of his own welfare is concerned. During this time he requires the care of parents. In the Christian concept of Matrimony, therefore, the primary purpose of marriage is the generation and education of children. It is because of the need for this education par-



ticularly that the family exists, even as a natural society.

Man, moreover, is by nature a social being. Only in rare cases is man content to live alone, and even in these cases the man who desires to live alone is looked upon as an exception and as an example of self-denial and mortification or as pathological in the psychiatric meaning of the term or as unfortunately unable to find or win his proper partner. Because of the mutual attraction between the sexes, the normal man and woman crave the companionship of the opposite sex; and, therefore, in the Christian concept of marriage one of the principal (though not the primary) purposes is the mutual consolation, comfort, and support of the parties to Matrimony. Note particularly that in the Christian concept of Matrimony the union is not merely a sexual union but a union of mind as well as of heart, and involves not only mutual satisfaction of carnal appetite but, even more important, frequently involves self-control and self-sacrifice in the interest of the partner's natural or supernatural health.

In the customary account of the Christian concept of Matrimony, another important though secondary purpose of Matrimony is the relief of concupiscence. In the words of St. Paul, those who cannot contain themselves should marry, since "it is better to marry than to burn." Even aside from considerations of the supernatural order, however, it is only too well known to those who are obliged to deal with marital disputes and difficulties that a marriage in which the relief of concupiscence is looked upon as the chief purpose of matrimony is at best a sorry state. Even in the natural order, sexual congress is normally the climax

of an unselfish mutual affection, and it is much more so in the Christian sacrament of Matrimony. Above all things, the permanency of Christian marriages as a supernatural sacramental state springs from its institution by Christ and its resemblance as described in the Scriptures to the unity between Christ and His Church.

## PREMARITAL INSTRUCTION AND EXAMINATION

A long struggle to overcome the results of Puritanism has finally resulted in an open public advocacy of sex instruction and the prevention of venereal diseases, and it is proper to refer here to the Catholic attitude toward these matters lest there be any misunderstanding of the Catholic teaching and lest it be confused with the puritanical attitude which is mistakenly identified with true religious teaching.

The necessity for premarital instruction, not only as regards the sacramental character of marriage but also as regards the proper exercise of the sexual function in marriage, is written directly into the Laws of the Church; and grave obligation is placed upon the pastor and confessor to see to it that persons contemplating Matrimony are instructed in this matter "either by himself or by a competent person such as a physician" (Can. 1033).

Moreover, by the Fifth Commandment all persons are forbidden to do injury to others, in physical health, in reputation, or spiritual health. The conclusion is clear that a person suffering from any communicable disease is obliged to refrain from communicating that disease to an-

other and to do all in his power to protect others from acquiring it. Therefore, a man or woman who is suffering from a communicable venereal disease is obliged, according to the Catholic teaching, to warn the prospective partner of the danger and to refrain from marriage or from the use of marriage until he is either cured or has at least arrived at a stage in the course of the disease in which it is not communicable. Certainly, if there is any reason to suppose that one party to a proposed marriage has been exposed to infection with a venereal disease, he should submit himself to proper medical examination to ascertain whether or not he is suffering from such disease and, if so, whether it is at the time communicable.

Therefore, the present campaign for the instruction of people with a view to protecting them from acquiring venereal disease, at least in its better features, is quite in accord not only with the Catholic doctrine but with Catholic practice for many centuries. It ceases to be in accord with Catholic teaching when it is used in such a way as to imply approval or condonation of extramarital sexual indulgence. Therefore, it should always be accompanied by an explanation of the necessity for self-control as a preparation for marriage. It also fails to be in accord with Catholic doctrine when it advocates the establishment by civil law of new impediments to matrimony, especially if they place too great restrictions upon human liberty. The authority to establish impediments to sacramental marriage belongs exclusively to the Church. Obviously, it further fails to be consistent with Catholic doctrine if it includes instructions

for prevention of venereal disease by the use of contraceptive devices or advocates contraceptive practices to prevent hereditary diseases.

The premarital physical examination should not be restricted to examination for venereal disease. Examinations for insurance contracts, as well as routine "check-ups," not infrequently reveal the existence of serious diseases entirely unsuspected on the part of the individual. Some of these diseases could easily be obstacles to marital happiness. Furthermore, cases present themselves in which an alert physician acquainted with psychiatry could have detected symptoms of psychosis which could render marriage invalid.

Tact, of course, on the part of the examining physician is not only good medical practice, but a moral obligation according to the Golden Rule. There is an old saying that people judge others by themselves. We all probably tend to think that matters familiar to us are equally familiar to all.

The following case is illustrative of a not uncommon attitude and a deplorable ignorance of how widespread is decency. One of the authors ordered the admission of a young woman to the hospital as a private patient, for examination, at the request of her employers. He directed the "house officer," a more than usually intelligent young physician, to take the routine history of the patient. The following conversation took place as part of the proceeding:

"Have you ever had gonorrhea?"



"What is gonorrhea?"

"Don't give me any of that stuff, you know what gonorrhea is. Have you ever had it?"

"Not that I know of."

"Have you ever had syphilis?"

"What is that, Doctor?"

"Listen, young lady, I am dealing with people like you every day. Don't try to put that business over on me."

The patient, knowing that discretion is the better part of valor, replied that she had never had the disease insofar as she was able to say. The house officer reported that there was a possibility that she had both gonorrhea and syphilis! Physical examination by the co-author later revealed her to be beyond doubt a virgin, and a few minutes conversation revealed that she was entirely unaware of the meaning of "gonorrhea" and "syphilis." A social service worker of the corporation employing the patient heard of the conversation from the girl and reported it to the head of the firm. The writer had difficulty preventing the expulsion of the young physician from the hospital.

This case demonstrates how harmful a simple procedure may be when unaccompanied by tact and how it can be to the advantage of young physicians to become familiar with the widespread innocence of Christian youth, lest they lay themselves open to being classified among those who "judge others by themselves." By innocence we do not mean ignorance, but many innocent people may well be unfamiliar with medical terminology.

We advocate measures to warn partners to prospective marriages about dangers to themselves and their possible



offspring, and we believe the warning should include more than merely venereal dangers. Undue emphasis can do more harm than good.

## IMPEDIMENTS TO MATRIMONY AND DISSOLUTION OF MATRIMONY

An impediment to matrimony is anything which causes an obstacle in law to a particular couple making the marriage contract. These impediments are set up either by Divine Law itself, whether natural or revealed, or by the laws of the Church. The Church has jurisdiction over the administration of the Sacraments, including Matrimony, directly from Christ, Who instituted them. Since the Sacrament and the contract are identical in Matrimony, the Church has authority to make laws governing the matrimonial contract for baptized persons. In practice, the Church can restrict the application of the law to Catholics as in cases of Disparity of Cult.

Some impediments are invalidating (*diriment*): that is, they render the marriage null and void from its beginning. Other impediments are merely prohibitive: that is, a marital contract made in spite of them is unlawfully made but, nevertheless, is a real marriage.

Defective consent may also render a marriage null, and so does failure to contract the marriage in the proper form. Furthermore, and this will be surprising to many, in certain quite exceptional cases marriage may be dissolved by the Pope. These cases will be explained in the following list.

For the information of nonclerical readers we offer here a list of the impediments to marriage, causes of defective consent, and reasons for dissolution of marriage as provided for in the Code of Canon Law. The Church's legislation regarding impediments to marriage can be found in the Code of Canon Law in Canon 1035 and subsequent Canons.

**Merely Prohibitive Impediments, Which Render Marriage Unlawful But Not Invalid:**

*a.* Simple Vows (Can. 1058). These include the vows taken by most of the religious congregations of Sisters or Brothers, as they are commonly known.

*b.* Legal Relationship (Can. 1059). This refers to relationship resulting from legal adoption in regions where the civil law considers it an impediment.

*c.* Mixed Religion (Can. 1060). This prohibits marriage between Catholics and baptized non-Catholics.

*d.* Unworthiness (Can. 1065–1066). This is not an impediment, properly so-called. Priests are forbidden to assist at the marriage of Catholics to those who have apostatized, or who are affiliated with forbidden societies, or who live in public sin, or who are notoriously under censure (for example, excommunication) unless for grave reason, with proper safeguards for the faith of the Catholic party and the children, and usually after consulting the Ordinary.

**Diriment Impediments, Which Render an Attempted Marriage Invalid unless Dispensation Has Been Granted:**

*a.* Age (Can. 1067). This impediment renders invalid

the marriage of males under sixteen years of age and of females under fourteen years of age.

*b. Impotency* (Can. 1068). This renders invalid the marriage of a person or persons unable to have sexual congress with each other. It may be "absolute," as in the case of a person who is unable to have coitus with anybody, or "relative," as in the case where coitus is possible to one or both of the parties but not possible with each other. Doubtful impotency is not included in this impediment. Sterility of itself is not an impediment in cases where impotency does not exist. Whether vasectomy renders a man impotent or not is disputed.

*c. Ligamen* (bond) (Can. 1069). This renders invalid the attempted marriage of a person already validly married.

*d. Disparity of Worship* (Can. 1070 and 1071). This renders invalid the marriage between a Catholic and an unbaptized person.

*e. Sacred Orders* (Can. 1072). This renders invalid the marriage of a person who has received any of the major Holy Orders, namely, Sub-Deaconate, Deaconate, or Priesthood.

*f. Solemn Vows* (Can. 1073). These are vows taken by members of certain religious orders. Solemn vows render invalid contracts entered into in violation of the vows.

*g. Abduction* (Can. 1074). This renders invalid the marriage of a kidnaped person and the kidnaper while the kidnaped person is still under the power of the kidnaper.

*h. Crime* (Can. 1075). This renders invalid the mar-

riage of two persons who have co-operated in crime against the spouse of one of them, with the intention of later marrying. The crime referred to is (1) adultery and promise of or attempted marriage with the co-adulterer, (2) adultery and conjucicide (murder of legitimate spouse of one), or (3) murder of legitimate spouse of one party to the proposed marriage by mutual co-operation (physical or moral) of the parties wishing to marry.

*i. Consanguinity* (Can. 1076). This renders invalid the marriage of blood relations, all in the direct line (for example, father and daughter) and in the collateral line (for example, brothers and sisters, cousins, uncles and aunts), to the third degree inclusive (second cousins).

*j. Affinity* (Can. 1077). This renders invalid the marriage of a person with blood relatives of his or her deceased spouse, all in the direct line and to the second degree inclusive (first cousins) in the collateral line.

*k. Public Decency* (Can. 1078). This renders invalid the marriage of a person to the blood relatives of another person with whom he or she has contracted an invalid marriage, or lived in public concubinage, in the direct line to the first and second degree.

*l. Spiritual Relationship* (Can. 1079). This renders invalid the marriage of a person with the person who baptized him, or his godfather or godmother.

*m. Legal Relationship* (Can. 1080). This renders invalid the marriage of those whose marriage is invalid by civil law because of adoption.

**Defective Consent.** Defective consent is not an impediment to marriage but is the absence of that agreement

which is essential to any contract. Defects in the necessary consent to the matrimonial contract may arise from (1) ignorance of the nature of the contract (Can. 1082); (2) error as to the identity of the person whom one is marrying (Can. 1083); (3) fiction or simulation, which is a merely pretended consent to marriage (Can. 1086); (4) violence and fear, in which a person is compelled by physical or moral force to go through the ceremony of marriage (Can. 1087); (5) conditions or intentions accompanying the contract against the permanence of marriage, mutual fidelity, or the right to procreation. If the matrimonial consent can be proven to have been vitiated by any of these causes, the marriage is null and void.

**Defective Form** (Can. 1094). "The form of Marriage" refers to the actual ceremony of making the contract. For Catholics, the prescribed form of marriage requires that the parties appear before a duly authorized priest (which means the Bishop of the Diocese or the parish priest, or a priest delegated by one of them) and two witnesses, in the territory of the bishop or pastor. The priest asks each of the parties for his consent to the contract and receives his consent, after which each of the parties may repeat the words of the contract to each other.

**Dissolution of the Marriage Contract.** It will probably surprise many of our nonclerical readers to learn that a valid marriage contract can, under certain circumstances, be dissolved by the Roman Pontiff. Canon 1118 states that a valid marriage of baptized people, ratified and consummated, can never be dissolved except by death. The ratification of a marriage here refers to the making of the



contract by two baptized persons. A consummated marriage is one in which the contract has been made and sexual congress has followed. Canon 1119 provides for the dissolution of a marriage which has been ratified but not consummated, that is, a marriage in which the contract has never been followed by sexual congress of the spouses. Such a marriage is automatically dissolved by the subsequent solemn profession of either of the parties, that is, by solemn vows in a religious order. The unconsummated marriage can be dissolved by Papal dispensation after the worthiness of the parties and the public good have been investigated and considered, leaving both parties free to marry. It is obvious that the proof of the nonconsummation of a marriage contract may involve medical examination and testimony. As a matter of fact, the Church requires, in the absence of medical evidence of physical virginity, the testimony of a number of witnesses to the effect that the parties to the contract had no opportunity for sexual congress following the contract or that they knew that something had seriously affected their marital life and joy.

Canon 1120 provides for the possibility of remarriage by reason of what is called the "Pauline privilege." Only in the case of marriage between two nonbaptized persons can this privilege be invoked, and then only when one of the nonbaptized persons has become a baptized Catholic and the other party to the marriage refuses to be baptized and live in peace with the baptized Catholic afterwards. The privilege is granted by the Pope and called "Pauline" because its scriptural authorization is found in St. Paul's

First Epistle to the Corinthians, Chapter VII. The first marriage (which was not sacramental, since neither party was baptized) is dissolved only when, by virtue of the privilege, one party now baptized contracts the second marriage, which is sacramental.

Certain of the above have medical interest because of the necessity of medical information, and sometimes medical examination, in order to substantiate claims made. These are particularly the Impediment of Impotency, both absolute and relative, and the cases in which the dissolution of marriage is sought on the ground of not having been consummated, or on the ground of defective consent by reason of insanity or mental deficiency. A discussion of the procedure of the medical examination and of the Church's Matrimonial Court procedure in taking medical testimony in these cases will be found in Chapter VIII.

#### VALIDATION OF MARRIAGE AND LEGITIMIZATION OF CHILDREN

In view of the widespread ignorance of the matrimonial procedure in the Catholic Church, we add here a few paragraphs of information regarding what is to be done in cases of marriage invalidly entered into by Catholics. We deal here only with Church law and practice, not with civil law. In a large number of such cases it is possible to bring about the conditions necessary for a valid marriage. In every diocese there is established by law an Ecclesiastical Matrimonial Court with Judges, Advocates, Defenders of the Marriage Bond, Secretaries, etc., the duty of which is to

investigate all matrimonial cases in which the validity of a marriage is called into question, or a petition for dissolution presented.

The parties to such marriages, therefore, should be advised to consult a priest (preferably, of course, one of the priests of the parish in which they reside). In some of these cases the solution is very simple. For example, a couple, one or both of whom are Catholics, who have attempted matrimony before someone other than a duly authorized priest and two witnesses need only to obtain the necessary authorization from the bishop through the priest and repeat the ceremony in the proper form. If one of the parties has been previously married, it is necessary to examine the previous marriage in order to ascertain whether or not it had been valid or whether one of the parties to it has died. If one of the parties has died, it is sufficient to procure a death certificate to prove it, in order to repeat the ceremony and validate the second marriage. If both parties to a previous marriage are alive, it may be investigated by the Diocesan Marriage Tribunal and, if discovered to be null and void, may be declared so by the Tribunal, and the subsequent marriage would be validated before a duly authorized priest and two witnesses.

The question of the legitimacy of children born from an invalid marriage also finds its answer in the practice of the Church in matrimonial cases. Many will be surprised to learn that illegitimate children become legitimate by the subsequent marriage of their parents, provided that the parents were canonically *able* to marry at the time of the conception, pregnancy, or birth of the children concerned.

Children born from invalid marriages are legitimate if either or both of the parents thought that the marriage was valid. In such case, the marriage is called a “putative” marriage. Such a case might occur where an invalidating impediment exists but is unknown to one or both parties at the time of the marriage, or where one party is discovered never to have been baptized and to have deceived the other party into thinking that he was, or in bigamous marriages where one party has fraudulently concealed his previous marriage.

## CHAPTER TWO

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### A FEW FUNDAMENTAL PRINCIPLES OF MORALITY

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CERTAIN FUNDAMENTAL PRINCIPLES of morality have such wide application in human behavior and especially in the practice of medicine that we consider them important enough to have a chapter devoted to their clarification. They are not as complicated as they appear to many, nor as they are sometimes made to appear by faulty reasoning.

#### INDIRECT VOLUNTARY

As a preliminary, let us state that an evil action directly performed is never lawful, even though it is done to produce a good result. In other words, a good end does not justify the means unless the means be morally good or indifferent. The principle governing the morality of an action innocent in itself but followed by two effects, one good and one evil, can be stated as follows.

Even though the original act is innocent in itself, an evil effect intended by the doer renders the act evil in intention and, therefore, sinful. If the evil effect is merely



permitted to follow, it is sinful if the original innocent action could have been omitted without proportionately serious inconvenience or if there is a special obligation to avoid the act innocent in itself expressly because of its evil consequence. The evil effect of an innocent action, permitted only because of another effect, in itself good, is not sinful, provided that the good is not the *result* of the evil and that the good accomplished is proportionate to the evil permitted.

Four conditions are necessary for the lawful performance of an action from which both good and bad results are foreseen:

1. The original action must be morally good or indifferent in itself.

2. The good effect must not be the result of the bad effect, but both the good and the evil effects must be the immediate result of the original action, or the evil effect must follow from the good effect rather than vice versa. Evil cannot be used to obtain a good end.

3. There must be a proportionately serious reason for doing the original action and permitting the evil effect. The good effect must be of equal or greater value than the evil.

4. The evil result which is foreseen must not be intended nor approved, but only permitted.

Two facts may be stated here in regard to obstetrical or gynecological procedures under consideration:

1. None of them is prohibited expressly because of the evil effect when the good and evil effects are both directly caused by a good or indifferent action and the good effects

are of greater value or at least of as great value as the evil.

2. In the application of the principle of the double effect, "indirect voluntary," there is no question of choice between saving the life of the mother and saving the life of the child, or of killing one to save the other. The physician does not directly will the death of either. Mother and child have an equal right to life. The physician has no right to kill the mother to save the child or to kill the child to save the mother. In the care of a pregnant woman he has two patients and is equally responsible for both.

The following diagram will illustrate the application of these rules in certain types of cases:

<i>Morally unlawful.</i> Therapeutic abortion. Action evil in itself. (Murder to save another life)	} Direct intentions	{ Life of mother ( <i>good</i> ). Murder of child ( <i>evil</i> ).
<i>Morally lawful.</i> Hysterectomy for cancer in pregnant uterus. Action good in itself.	} Direct intention and effect — Life of mother ( <i>good</i> ) } Indirect effect — Death of child ( <i>permitted</i> )	
<i>Morally unlawful.</i> Direct abortion to avoid defective children. Action evil in itself. (Murder for social purposes.)	} Direct intention and effect — Death of child } Direct intention and possible effect — Social security	

<i>Morally lawful.</i>	}	
Operation to control hemorrhage during pregnancy before viability.		
Action good in itself.		
		Direct intention — Saving life of mother
		Indirect possible effect — Death of child
<i>Morally lawful.</i>	}	
Treatment of possibly fatal concurrent disease in pregnant woman.		
		Direct intention — Adequate legitimate treatment for serious disease
		Indirect possible effect — Death of child
<i>Morally lawful.</i>	}	
Hysterectomy in nonpregnant woman, or excision of testes, ovaries or tubes necessitated by tumors, or other disease.		
		Direct intention — Saving life and health threatened by disease
		Indirect effect — Sterility and mutilation
<i>Morally unlawful.</i>	}	
Sterilization for economic or social reasons.		
	Direct intentions	Mutilation and sterility ( <i>evil</i> ).
		Economic or social advantages ( <i>good</i> ).

## SCANDAL AND CO-OPERATION IN EVIL IN MEDICAL ADVICE

The second fundamental principle to be remembered by physicians in their practice is that of scandal, which is defined by St. Thomas Aquinas as anything, word or deed, of lesser worthiness which presents to another an occasion of spiritual ruin.

It has come to our attention in enough cases to warrant mention here that Catholic physicians, sometimes in good faith because of ignorance or thoughtlessness, refer patients to other physicians for such things as therapeutic abortion, sterilization, advice about contraceptive devices and measurement for them, and the like. Their opinion seems to be that they cannot as Catholics do these things themselves, but that they can send their patients to others or call others into consultation for the purpose. This attitude is also found in non-Catholic physicians who do not feel that they can do these things ethically. In referring patients in this way, the physician gives scandal to a serious degree both to the patient and to the physician to whom he refers the patient, since he gives other human beings the opportunity to do the wrong which he knows he cannot in conscience do himself. This is true regardless of whether either is Catholic, since the natural divine moral law is binding upon all. This is also true of those who manufacture, advertise, sell, or recommend contraceptive devices.

In regard to abortion, therapeutic or criminal, those procuring abortion, including the mother, incur excommunication when abortion takes place. The declaration by Church authorities is not necessary in any particular case. Absolution from the excommunication is reserved to the bishop of the diocese or other similar authority before absolution from the sin (murder) can be given. "Those procuring abortion" include those who command or co-operate in procuring it. This includes physicians and others who advise or urge it (Canon 2350, Code of Canon Law).

## SOME DUTIES OF PHYSICIANS AS CITIZENS

The third principle concerns the duties of citizens. The authority of the state, which includes cities and towns, states, nations, and even the United Nations, comes from God Himself even though the governments which exercise the authority may be in some cases, such as the United States, chosen by consent of the people.

Governments can have no authority to make or enforce human laws which are in conflict with Divine Law. It is the serious duty of citizens to guide themselves by this fact when they vote, hold public office, or have any occasion to use their influence in the home, in the schools, in places of work and recreation, in lecture halls, on the stage or radio, in books and magazines, and in the legislatures, administrative offices, and courts. The individual is personally responsible for the moral state of the nation to the extent to which his vote and other actions can help influence it. We are thinking here especially of laws regarding divorce, contraception, sterilization, and so on.

## CONSCIENCE AS A GUIDE

A fourth matter is worthy of mention here, namely, conscience as a guide for actions. Correctly understood, the conscience is the intellect or power of thinking or understanding when it is used to determine the conformity or nonconformity of an act contemplated or performed with the divine moral law as far as that law is known to the person concerned. It is the same intellect which is used for



any other purpose and is a good guide if the person knows the moral law.

The use of conscience as a guide is normally accompanied by feelings of self-approbation, shame, remorse, guilt, and the like which are the result of the activity of the emotional center in the brain known as the hypothalamus. These feelings are normal and healthy reactions when they result from one's awareness of willing what is good or bad. They can, however, be conditioned or trained by one's self or one's environment so that guilt feelings or remorse can result from good or indifferent acts of will (as in scrupulosity) or so that no remorse results from bad actions (as in moral laxity or confirmed vice of any kind). These feelings are correctly called the moral sense in psychology. They are incorrectly called the conscience by many modern psychologists. In psychoanalysis, this moral sense, or conscience falsely so called, is attributed to an equally mislabeled "super-ego."

The wrong training of the moral sense, whether by intent or otherwise, provides a very dangerous feeling of security for those who maintain that certain things are not sinful for them because their "conscience does not bother them," as well as a fruitful source of psychoneurosis of the variety known as scrupulosity for those who feel guilty when they are innocent.

## CHAPTER THREE

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# SEXUAL CONSTITUTION

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## INTRODUCTION

SEX is not something apart or distinct from the rest of the human organism or, for that matter, from the rest of any animal organism, but is an integral part of the human individual. The Church has commonly and mistakenly been accused of too much repression or suppression in its teaching regarding sex. This mistaken conception of the Church's attitude toward sexual matters is probably due to ignorance, on the one hand, of the Church's teaching, and, on the other hand, of the real nature and ramification of the sexual element in the human organism.

A consideration of a few facts known to all will be enough to indicate that sexual characteristics and activities are not limited to what are commonly called the sex organs. Although we do not agree with all teachings of the Freudian school or even the principal ones, there is nevertheless an element of truth in the implication that there is some sexual element or influence concerned in most, if not all, of man's actions. Consider for a moment the so-called secondary sex characteristics. Included among these are the

general bodily outline, the distribution of hair, the shape of the bones of the skeleton, the differences in voice, in mannerisms, in tastes in regard to play, dress, occupation, and companionship, and many other differences between the sexes among normal people. These differences are not only influenced by environment and companionship during childhood and youth, but are also profoundly influenced by the activities of many glands in the body, which, until modern discoveries, were not considered to have anything to do with sex characteristics. For example, there are the thymus gland in the chest, the pituitary gland in the head, the thyroid gland in the neck.

Furthermore, there are abnormalities of the sexual constitution which also emphasize the profound influence on the whole individual of physiological sexual differences. There are unfortunate individuals who, from causes at present only obscurely known or guessed at, have no taste for the companionship of people of the opposite sex, but have a strong attraction for people of the same sex as themselves. These people are known as homosexuals. The results of recent research appear to indicate that the abnormality in these people is so profound that it not only influences in many cases the voice, the mannerisms, and sometimes the bodily contour and distribution of hair, but when constitutional may also be recognized by the examination of the relative amounts of male and female sex hormones in the urine.

Among the members of the animal kingdom, exclusive of man, the sex life in the common meaning of the term (that is to say, the activities associated with mating) occurs with

a certain periodicity and is seasonal in its variation, so that, in the intervals between mating seasons, the animals ordinarily do not indulge in these activities. Whether as the result of the baneful elements of so-called civilization or as an indirect result of the injury done to human nature by original sin or for some other reason, the human animal does not confine his overt sex activities to any particular periods, but he can and does exercise them at all times. As a result of this, the sexual life of man includes disorders which give rise to serious problems of economic, emotional, and moral nature. It seems to us, therefore, that a knowledge of the sexual constitution of the human individual is important for all those who deal with human problems and difficulties, particularly the priest and the physician. As a matter of fact, until recently, even the physician in the course of his education frequently learned little or nothing of the sexual constitution of man in its deeper significance, particularly for mental health. In regard to the mutual influence of the sexual constitution and the supernatural life, also, an understanding of the sexual constitution can certainly be of great assistance to the priest in correcting the misconceptions of the disturbed and scrupulous, on the one hand and the lax and possibly vicious, on the other hand. This understanding also helps both priest and physician, since the general health of an individual depends, to a large extent, upon the proper regulation and control of sex life. These matters will be seen more clearly in subsequent paragraphs.

It must be remembered also that there are gradations in the secondary sex characteristics in different individuals.

Thus, we see the "manly man," the "womanly woman," the "effeminate man," and the "virile woman." The extreme is found in the true hermaphrodite, who exhibits a mixture of the characteristics of both sexes and harbors both ovarian and testicular tissue. These persons are rare. Most so-called hermaphrodites are of a single sex, with abnormally developed external genitalia.

## THE GENITALIA

**The Gonads.** It is not our purpose here to give a detailed description of the organs of reproduction, since that would be useless to the physician and superfluous for the priest. It will be enough to describe their structure and function in so far as is necessary to provide the background for an understanding of the moral problems involved in their function, and in the medical treatment they may require.

The organs of reproduction consist of the ovaries in the female and the testes in the male. These are called the gonads and are the organs which serve the purpose of bringing together the germ cells (ovum and spermatozoon) and which provide a nest ("nidus") for the nutrition and growth of the offspring until ready for birth.

The process by which the ovum and spermatozoon are generated in the gonads is complicated. If the reader is interested in it, he should consult any standard textbook in biology, histology, or obstetrics. The gonads or, rather, the tissue in them generating the germ cells, are referred to as "germ plasm" as if they had a quasi-independence and permanence apart from the rest of the individual harboring



them. The end result of this process in the female is the ovum or egg-cell, which contains one-half the number of chromosomes as are contained in the rest of the cells of the parent body.

The chromosomes are the bearers of the genes, which carry the hereditary characteristics. The male germ cell (the spermatozoon) also contains one-half the number of chromosomes as are found in the body cells of the parent. It will be seen that when the ovum and spermatozoon unite to form a single cell (fertilization), this resultant cell, the fertilized ovum, will contain a number of chromosomes equal to the body cells of the species. The germ cells carry the hereditary characteristics from the parents to the offspring. The study of their transmission is known as genetics. The attempt to improve the race by the regulation of transmission of "genes" (the bearers of hereditary characters in the germ cells) is called eugenics.

The ovaries are located within the pelvis, or lower part of the abdominal cavity, one on each side. They are oval-shaped structures and vary in circumference from an inch to two inches. The ova are generated near the surface of the ovary and, when mature, are expelled into the abdominal cavity by the rupture of the fluid-filled vesicle (resembling a blister) in which they lie. This occurs in the human female approximately every twenty-eight days, from puberty to the menopause. This expulsion of the ovum from the follicle, as it is called, is known as ovulation. Its periodicity, however, may vary in different women and occasionally in the same woman.

The estimation of the date of ovulation is important for

several reasons, among them the prediction of the date of birth of children, the estimation of periods when pregnancy is most likely to occur whether in order to promote it or to avoid it, and in some medico-legal cases.

The testes, also two in number, are located in the skin sac known as the scrotum. They originate in the abdomen as do the ovaries, but during the intra-uterine life descend through the inguinal canal between layers of the abdominal wall at the groin into the scrotum. In the female the thickened skin and subcutaneous tissue corresponding to the scrotum remain as the *labia majora*. The testes are somewhat larger in size than the ovaries.

The spermatozoa are generated in the extremely intricate system of microscopic tubes in the testes. From these tubules they pass through larger passages known as the *vasa efferentia*, into the epididymus, which is adjacent to the testes. Thence they go through the *vas deferens* and up through the groin to the seminal vesicles, sacs near the prostate gland under the urinary bladder, where they are mixed with prostatic fluid and from which they are ejected into the urethra through the penis. The seminal vesicles are elastic muscular organs. It is now estimated that an ordinary ejaculation contains from 300 to 500 million spermatozoa.

Spermatozoa are generated from approximately the age of puberty to an indeterminate age. Exceptions, of course, occur. Ejaculations of prostatic fluid from the seminal vesicles may take place without spermatozoa before or after puberty.

The gonads, by means of cells other than those which

generate the germ cells, produce substances known as hormones, which pass into the blood stream and profoundly influence the organism.

The pituitary gland in the cranium is the source of two substances of hormonal nature which stimulate follicle formation (the ovum-bearing sac) in the ovary and spermatozoa production in the testis. In the male, one component of the pituitary stimulates the endocrine cells of the testis to produce the male sex hormone. This component of the pituitary is obtainable and is usually administered in the form of "testosterone propionate." It is of value, among other things, in the treatment of the loss of both testicles, of undescended testicles in the infant, and of the symptoms of so-called male climacteric and in the relief of some symptoms in old men. It will be referred to later in connection with the treatment of infertility, when the influence of the thyroid hormone on spermatogenesis will also be mentioned. Substances which stimulate the gonads are called gonado-tropins.

**The Female External Genitalia.** The female generative organs may be classified as external and internal. When one refers to the external organs, the term "vulva" includes all of the external female generative organs. That part of the lower abdomen above the *symphysis pubis* (the mid-bone of the pelvis in front) which, after maturity, is covered with a hairy growth is known as the *mons veneris*. The two thickened areas between the inner aspects of the thighs, extending towards the midline to the vaginal orifice and extending downward from the *mons veneris*, are known as the *labia majora*. Directly in front of the *symphysis pubis*

and within the *labia majora* is a small organ called the clitoris, the homolog of the male penis. This organ is protected by an enveloping tissue called the prepuce (foreskin). Extending downward on either side from the clitoris and finally ending at the vaginal orifice on either side are the *labia minora*, two smaller folds of skin enclosing vascular erectile tissue. Situated externally to the vagina, in fact, right at the opening of the vagina on either side, are two glands called Bartholini's glands, the function of which is to secrete an oily lubricating fluid. Approximately midway between the clitoris and the vaginal opening is the meatus, or opening of the urethra (the tube from the urinary bladder). The area above the meatus and below the clitoris is spoken of as the vestibule. *Of these external genital organs the clitoris, labia minora, and Bartholini's glands play a part in sexual congress.* The anatomy and circulation of the clitoris and *labia minora* are such that they are capable at that time of increased vascularity and resulting erectility. The function of Bartholini's glands, as stated above, is merely that of lubrication, an oily fluid being secreted at the time of sexual congress. The function of the other external genital organs can be described as being supportive and sensory.

**The Female Internal Genitalia.** The internal organs are the vagina, the uterus (womb), the Fallopian tubes, the ovaries, and numerous ligaments for support.

a. The *vagina* is the female organ of copulation, varying in length from  $2\frac{1}{2}$  to  $3\frac{1}{2}$  inches, into which the seminal fluid from the male is ejaculated. When a woman is in an upright position, it has an upward and backward direc-



tion. The shape of the vagina is such that its diameter increases in size as it approaches its uterine and ligamentous attachments. The vagina has another function in that it is the canal through which, during labor and birth, the baby must pass after leaving the cavity of the uterus. The orifice between the vagina and vestibule is protected by a membrane of skin and connective tissue called the hymen. It almost always has an opening (perforation) of varying size, but occasionally is imperforate. When imperforate it causes difficulties when menstruation begins, and then surgical interference is indicated. The hymen is torn (ruptured) or stretched by sexual congress, by examination of the vagina, by operations through the vagina, or by certain devices, widely advertised at present, to be worn within the vagina during menstrual periods. The hymen is important in medico-legal cases and in the question of unconsummated marriage, since an intact hymen is the most important item of evidence of physical virginity.

*b.* The *uterus* is divided into two parts: the cervix, or neck of the uterus, and the fundus, or body of the uterus. The cervix is the lower part of the uterus and protrudes into the vagina from above. The fundus is that part which is in the abdominal cavity. The uterus, both cervix and body, is composed mostly of muscular and connective tissue. It is of this structure to enable it to expel from its cavity the products of conception (that is, the baby, membranes, and afterbirth) by muscular action, which is truly called labor, since it involves hard work. If a woman becomes pregnant, the fundus must expand to many times its ordinary size to make room for the baby. To allow for this



expansion, there must be connective tissue. The structure of the cervix is very much the same as that of the body of the uterus, since it must be greatly dilated during labor to allow the passage of the baby.

c. The *Fallopian tubes* are two smaller tubular structures, one on either side of the uterus, furnishing passage between the inside of the uterine cavity at the upper and outer corners and the abdominal cavity at points near the ovaries. The Fallopian tubes run one on each side from the cornua (upper and outer corners) of the uterus in a rather tortuous course outwardly toward the ovaries. The Fallopian tubes make it possible for the spermatozoon to come into contact with the ovum in order that conception may take place and for the fertilized ovum to make its way from the abdominal cavity to the womb. The outer aperture of the Fallopian tube is much larger than is the uterine end and is known as the fimbriated end and opens into the abdominal cavity near the ovary. The Fallopian tubes are about 3 to  $3\frac{1}{2}$  inches long and about  $\frac{3}{8}$  to  $\frac{1}{2}$  inch thick on the outside. The lumen between the fimbriated ends and the cornua of the uterus, that is, the place where the tube opens into the uterus, is so narrow that it would be difficult to insert in the lumen a common household pin. There is no provision for hypertrophy or dilatation, as there is in the uterus. Obviously, the lumen of the tube is designed for the passage only of microscopic or extremely minute objects (spermatozoa and ova). This fact is important in the consideration of extra-uterine pregnancy.

The *ovaries* are two in number, one situated on each side and each supported in place by an ovarian ligament

attached to the outside of the uterus. The ovary is not constant in size, and may be described as varying from that of a hazelnut to a walnut. The ovary lies free in the peritoneal cavity, supported by the ovarian ligament. It controls both menstruation and ovulation. In the ovary, the primitive female germ cells undergo the process of maturation. When mature, the ovum lies almost free, attached by a small stem in a small sac, which is otherwise filled with fluid. This sac is located at the surface of the ovary. When the ovum is fully mature, the sac breaks and the ovum is expelled into the abdominal cavity. This process is called ovulation and occurs in most women at definite intervals of time, usually every twenty-eight days. After ovulation, a series of events take place which are designed to prepare the organism for pregnancy and which result in menstruation if pregnancy does not occur.

*d. Corpus Luteum.* The cavity left by the rupture of the sac is filled in by the surrounding tissue, which assumes a new form, and the resulting body which replaces the ruptured sac is called the corpus luteum. The corpus luteum plays an important role in subsequent events (either menstruation or pregnancy), as will be described later.

*e. The Preparation of the Endometrium for Pregnancy.* The endometrium is the lining of the uterine cavity. At the same time that ovulation occurs, this lining undergoes changes which are a preliminary preparation for "nidation." The uterine lining is prepared as a nesting place for the growth and development of the new organism formed by fertilization of the ovum if such fertilization should occur. This change consists principally of a hypertrophy

(overgrowth) of the uterine lining. The lining becomes thick and soft, and the blood vessels are increased so much in number and size that the uterine lining is filled with large blood spaces. If the ovum is fertilized and imbedded in this hypertrophied lining, it must derive its nourishment from the blood of the mother by a process to be described in the discussion of pregnancy. Hence, the preparation takes place.

*f. Influence of Other Endocrines.* The hypertrophy of the uterine lining is known to be influenced by certain chemical substances, known in general as hormones. Many hormones governing many other functions of the body are known, but here we are interested only in those formed by the pituitary body and the ovary. The pituitary is a small body, less than one-half inch in diameter, located inside the cranium and attached to the base of the brain. It is formed originally in the embryo by tissue from the pharynx (throat) and tissue from the brain. Although small, it manufactures hormones of great importance. Disturbances of some of its functions result in profound changes, for instance, a certain form of gigantism (giantism) and certain forms of abnormality in development of the sex organs. One recently discovered pituitary hormone is the now highly publicized ACTH (adreno-cortico-tropic-hormone) which gives promise of great value in the treatment of several hitherto intractable serious diseases.

Among the pituitary hormones are two, known as prolactin "A" and prolactin "B," which stimulate and regulate the function of the ovaries to some extent by causing the ovaries to liberate hormones known as estrin and progesterone.

These hormones cause the hypertrophy of the uterine lining.

In the meantime, the corpus luteum produces another hormone which, in the event that the ovum is not fertilized, causes the hypertrophied lining to become separated from the underlying wall of the uterus and shed into the uterine cavity, accompanied by a considerable amount of blood. This endometrium and blood make up the menstrual flow. If the ovum is fertilized, the progesterin from the ovary so affects the corpus luteum that the latter assumes a different hormone action, important in the early months of pregnancy, an action which prevents the separation and shedding of the uterine lining.

*g. Menstrual Flow.* Menstruation occurs periodically at an interval of time similar to the interval at which ovulation occurs. Menstruation is the shedding of the endometrium and the accompanying hemorrhage which escapes from the uterus through the vagina and external genitalia. Menstruation begins twelve to fourteen days after ovulation occurs unless, of course, the ovum is fertilized. In practice, therefore, the date of ovulation is learned by estimating the twelfth to the fourteenth day before the date on which, in any given individual, menstruation is expected to begin. The periodic occurrence of ovulation and menstruation begins at puberty which takes place usually at the age of about 12 to 14 and continues until the period known as the menopause (change of life), which occurs at the age of approximately 47. At the time of menstruation many women are subject to pain and other discomforts varying in degree. Much of this can be relieved by proper medical treatment without recourse to quackery. At this



time, also, women are accustomed to wear some kind of protection to avoid soiling their clothing. There is no good reason why they should be unduly sensitive about it, since the "period" is a perfectly normal, healthy occurrence, a fact, which incidentally should be explained to girls at puberty. We do not at all approve the use of devices for wear during menstruation which are made to be inserted into the vagina for the widely advertised purpose of avoiding "embarrassment" when wearing bathing suits, evening gowns, and the like. Such devices destroy the physical evidences of virginity by their insertion and may, like anything inserted into the vagina, furnish a stimulus to masturbation.

#### CARE OF THE GENITALIA IN INFANTS AND CHILDREN

From the beginning of infancy, children of both sexes show evidences of sexual impulses. Until puberty, these impulses are due wholly to activity of the sensory nerves in the pelvic organs. At least, there is no evidence that hormones play any part in them at this age. Signs of infantile sexual stimulation are seen in the boy infant and young child when the prepuce (foreskin) is retracted from over the head of the glans penis unless it is done quickly and carefully, and is seen in the girl infant under comparable stimulation. The habit of masturbation is sometimes acquired innocently by young children, either accidentally or, unfortunately, by manipulation of the genital region in the effort to quiet the child.



The glans should be kept clean as any other part of the body is. At the attachment of the prepuce to the penis are glands which secrete a lubricant called smegma, which may turn waxy and prove an irritant if allowed to accumulate under the foreskin. To prevent these sources of unnecessary irritation and for the sake of routine cleanliness, it is a common practice to circumcise all male infants soon after birth. The retraction of the foreskin may serve the same purpose. The uncovered glans becomes less sensitive to mechanical stimulation from clothes.

Children, especially boys, should be taught in early life to take proper hygienic care of their genitalia. It happens not infrequently that a tight foreskin is forced back over the glans and cannot be replaced by the boy or man and, because of false modesty, is allowed to remain until pain, swelling, or even beginning gangrene or inability to urinate forces the victim to seek proper medical advice and treatment.

Boys in the prepubertal age are capable of having erection and sometimes may have a discharge of prostatic fluid. At this age, too, they are capable of penetrating the vagina.

The treatment of children who are discovered to be indulging in sexual practices requires great wisdom and skill on the part of parents and others, including priests and physicians. Frequently these habits are acquired innocently, at least on the part of the child; and anything in the nature of punishment should be accompanied by instruction adapted to the intellectual powers of the child. The treatment of adults who deliberately initiate the child in these practices is usually a matter for the criminologist,

aided if necessary by a competent psychiatrist. Kindly treatment should never be allowed to be interpreted as condonation.

It is frequently advised that young children of both sexes be bathed and even allowed to play together in the nude, in order to become accustomed to bodily differences in the sexes. We consider this to be entirely unnecessary and only too frequently baneful. Even those products of human decadence usually called savages and euphemistically called "primitive" are accustomed to shield their "private parts" from public view. Children need to be educated in sex as in all matters from birth onward; and a decent respect for themselves, without tinge of either scrupulosity or licentiousness, should be included in their education. It is best done by their parents, aided if necessary by others, in a manner suited to their power of learning.

## PUBERTY AND ADOLESCENCE

**General.** Puberty is the age period when the child begins to develop adult characteristics. It may be called the beginning of the adolescent period. It is marked, among other things, by the appearance of menstrual periods in the girl and, less noticeable, by the production of spermatozoa by the boy. We say "among other things" because puberty and adolescence are also marked by profound and sometimes spectacular alterations, physical, mental, and emotional, involving the whole organism.

At puberty, endocrine activities are added to those of the nervous system regulating sexual feelings and func-

tions. By endocrines are meant chemical substances made by especially differentiated glandular tissues and delivered by the latter directly into the circulating blood. They are many in number and serve many purposes. Their products are called hormones. In a work of this kind, we are particularly concerned with hormones secreted by the pituitary gland, the gonads, and, to a lesser extent, the thyroid and thymus glands, although all the endocrines interact among themselves and with the nervous system to a marvelous degree. We mention the thymus gland here as a matter of interest rather than as having anything to do with moral problems. It is a small gland situated in the chest behind the sternum (breast bone). Ordinarily, it atrophies at the time of puberty. In some cases it atrophies earlier, so that an earlier puberty and a small adult results. When it fails to atrophy at this time, it may cause a delayed puberty and result in a larger individual with childhood characteristics persisting for varied lengths of time. An enlarged thymus is frequently associated with the condition known as "status lymphaticus," the first recognized indication of which is abruptly sudden death, otherwise unexplained.

Puberty, as indicated by the beginning of menstrual periods, begins in the girl at about the age of twelve, but is subject to considerable variation. Its beginning in the boy is probably later, but is difficult to determine, since there is no such obvious sign as menstruation. It is probably also more gradual in the boy.

The onset of puberty is followed by a continuing progress toward maturity, that period productive of problems for

the child and all who deal with him, parents, teachers, clergy, physician (including psychiatrist), social workers, probation officers, and a host of others, not to speak of the much called upon, but seldom thanked, policeman.

During early adolescence, there appears the very noticeable change aptly called the "adolescent spurt." To the ordinary acquaintance, it appears chiefly as a rapidly increasing growth in height, because of an accelerated growth of the long bones of the extremities. At the same time, obviously, there is an equally rapid growth in the muscles attached to these bones, in the nerves which control them, and in the blood vessels which carry their food and oxygen supply, not to speak of the connective tissue and tendons which support them. All this makes for some awkwardness, of which the adolescent is aware, and about which he can easily become hypersensitive, especially if he is frequently reminded of it and reprimanded or ridiculed because of it. Such an attitude on the part of others toward the child can easily result in excessive bashfulness and a permanent feeling of inferiority. The latter can in turn cause a permanent reluctance to "mix" with others, or may be compensated for by the effort to become or appear superior, sometimes by antisocial activity.

During this stage of life many other changes take place in the organism which are less obvious to the eye. As a rule, they occur earlier in the girl than in the boy. As one example, let us take one of the theories advanced to explain why stuttering is more common in boys than in girls. Incidentally, there is no commonly agreed-upon cause or treatment of stuttering. The point here is the



fact that in a very large proportion of cases it spontaneously disappears earlier among girls than among boys. It has been demonstrated that myelinization (another indication of maturity discoverable only by microscopic examination of the brain after autopsy) of the speech center in the brain occurs in girls at a younger age than in boys.<sup>1</sup> Myelinization is the maturing of the tube-shaped cells surrounding nerve fibers. These "myelin sheaths" insulate the nerve fibers much as the insulating material does to wires in electrical work, thus preventing short-circuiting. Destruction of the myelin sheaths in some diseases results in muscular incoordination, sometimes of the muscles of articulation.

The sex urge, then, is only a part of the experiences of the child during adolescence. The entire maturing process during this period may be called a crisis comparable and more important in its possibilities than the menopause. The earlier maturing of girls physically, mentally, and emotionally can account for the fact that girls at this age as a rule prefer the companionship of older boys or men, while boys of the same age frequently become overbashful or resentful concerning what they feel is the superior attitude of their chronological equals.

**Masturbation.** Masturbation is sufficiently common in childhood and adolescence to require discussion here. It is the production of sexual orgasm by the person himself or herself without sexual congress, although it is sometimes assisted or initiated by others as in the case mentioned in the discussion of infants. Since masturbation is usually

<sup>1</sup> Isaac W. Karlin, *Journal of the American Medical Association*, June 24, 1950.



practiced by a person who is alone and is a source of physical pleasure and satisfaction and relief of sexual tension, it very easily grows into a habit difficult to break. Some facts concerning it, both medical and moral, and some common misconceptions about its effects should be clarified to dispel sources of unjustified terror and to help priest and physician, together with parents, to strengthen the child in the effort to abstain from it or to overcome the habit.

The evil results of the act or habit are chiefly in the supernatural realm, since masturbation is always a mortal sin when performed with sufficient reflection and full consent of the will. Without these two specifically human acts, there can be no mortal sin of any kind, in the sexual or in any other sphere of activity. The guilt of an action is lessened, or is absent, by the degree in which knowledge or exercise of free will is diminished, or is absent. A person who is tormented by an habitual urge and sometimes falls "in spite of himself," in spite of doing all in his power to overcome the habit, needs encouragement in his struggle and advice in devoting his attention to legitimate occupations, and above all should increase his use of the Sacraments and prayer. He should fear the loss of friendship of God, rather than what he thinks is the prospect of going to Hell for something he knows from experience is not entirely subject to his own control. This is far from subscribing to a too common custom prevailing among some of our colleagues, who give reassurance on the basis of a denial of sin and consequent guilt, and even advise indulgence in

the practice. In some severe cases of persistence of the habitual urge in adults, medical treatment is useful.

It is also far from the unwarranted warning that masturbation causes "insanity" or other terrifying diseases. The fact is that it does not. Stress should not be laid on instilling fear lest faith or confidence in the advisor be undermined when the person learns that the advice was based on ignorance of the facts. Fake advice may also lead to neuroses. The misconception probably had its origin in the observed fact that some patients in hospitals for mental diseases masturbate openly because of their mental derangement.

Masturbation is by no means universal. It is often asserted to be so, possibly as a rationalization by those making the assertion or as a result of their limited acquaintance with humanity.

The physio-mental (or psychosomatic, to use the current terminology) evil results in the natural order lie entirely in the neuroses, chiefly of the anxiety type mentioned above, or in the weakened moral fiber resulting from prolonged indulgence. Emotions in general, including sexual impulses, are responses of the sentient order and the result of the activity of the thalamic area of the brain. They are the normal reaction to certain kinds of stimuli and can be conditioned (trained) either accidentally or purposely. The result is habituation. The cure is self-rehabilitation guided by intelligent understanding and supernatural as well as natural help.

The sexual urges in the adolescent are not very different

from those in the adult except that they are new experiences and one of the elements causing the general interior confusion. Children are likely to find themselves in the middle between an ultra-reticent attitude toward sex on the one hand, and an ultra-libertine one on the other, silenced by unjustifiable taboos by one and tempted by companions and the purveyors of pornography, sometimes wearing the cloak of science, on the other. In this matter, more than anything else, they need proper and wise guidance and education, fortified by supernatural grace through prayer, self-discipline, and the Sacraments.

**Sex Education.** Sex education in the schools, if to be given at all, should be given in conjunction with a course in physiology, with instruction in other functions of the organism and emphasis on the duty imposed by the Fifth Commandment as well as Nature to respect the lives and health of one's self and others. The exercise of the sexual powers is reserved by God to the state of matrimony. Matters pertaining to it should be known and understood, and the child should be taught that its wrong use leads only to natural and supernatural disorder.

A gradual emancipation from parental domination is a normal part of maturation in the adolescent and youth, especially in the emotional life. Its discussion is not within the scope of this book, but it should be borne in mind by parents and by their priestly and medical counsellors. The effort to retain too long the parental control suitable for children is productive of incalculable harm to the later welfare of the grown offspring.

## ADULT LIFE

The sexual aspects of adult life will be sufficiently discussed in subsequent chapters. It is enough here to point out again that the exercise of the sexual functions should be limited to marriage, to refer to what constitutes fornication and adultery in the theological meaning of the terms, and to say a word about celibacy and continence, and finally about the menopause or "change in life."

Fornication is the sexual congress of a man and woman (of any age) both of whom are unmarried. It involves two mortal sins on the part of each, a sin against the virtue of purity and another against the virtue of charity, since each party is causing or encouraging the other in serious sin.

Adultery is the sexual congress of two parties of opposite sexes, one or each of whom is married to another. The same sins of impurity and scandal (that is, causing or co-operating in the sin of another) are involved. Also, the married party is guilty of a sin of injustice against his own spouse, and the other party, if unmarried, is guilty of a sin of injustice against the spouse of his or her partner in sin. If both parties are lawfully married to others, each commits two sins of injustice, one against his own spouse and one against the other's spouse, so that each commits four mortal sins.

Continence is the state of living in which a person confines sexual congress to the legitimate use of lawful marriage or, if unmarried or widowed, entirely omits it.

Celibacy is the state of living in which sexual congress

and all other sexual indulgence is omitted. It is perfectly possible and healthy to lead a celibate life. The assertion that it is not possible is a pure calumny against the unnumbered priests, religious sisters and brothers, and lay people who live celibate lives. When celibacy is adopted in imitation of Christ and for the purpose of devoting one's life to the labors of religious life or works of charity dedicated to God, as it is with great frequency although it is seldom appreciated, it takes on a supernatural quality and value. To label this celibacy as a mere sublimation of libido (sex energy), as some psychiatrists, educators, and others do, is at best a sign of ignorance. We have seen students and patients who have been given to understand that there is "something wrong" with young men and women who reach the early or mid-twenties in age without having had what is called "sex experience."

## THE CLIMACTERIC

**Female.** The menopause, properly so called only in the female, is commonly considered another crisis in life, the reverse of puberty. At this time the cycle of events from ovulation to either menstruation or pregnancy ceases, and conception becomes biologically impossible. This period begins at the age of approximately forty-seven years and usually lasts a few years. As in puberty, the age of onset varies.

Until the advent and growth of new discoveries concerning hormones and their use in gynecology, many women suffered greatly during the menopause, as also did



many of their families and near associates. They exhibited emotional instability marked by great mental irritability, apparently unreasonable bursts of tears, and depression to the point that harm to themselves or others could be seriously feared. Added to this, many showed forgetfulness, suspicions, outbreaks of temper, "tantrums," and many other symptoms and signs. The symptom common in all cases was the occurrence of hot flashes or flushes, characterized by the sudden experience of waves of heat and skin redness lasting only a few minutes but coming at any and all times.

Today, with the proper use of female hormones provided by reliable drug manufacturers and used under competent medical supervision, all of these symptoms can be prevented or greatly alleviated in 99 per cent of women; the remainder are as a rule of an unstable type previously and expect trouble because it is the tradition in the family. Even in the latter type the hormone treatment produces relief.

It is well for the priest to be aware of this occurrence, since he is quite likely to be consulted by women in this stage of life.

**Male.** The so-called male "change of life" is an almost unnoticeable and gradual diminution in sexual powers and inclination, at least in most men. It is accompanied in many cases by emotional and physical symptoms, most of which have their counterpart in other activities, for instance, muscular, digestive, recreational, and so on, of the aging man. Symptoms usually associated only with the female climacteric, such as hot flashes and flushes, have been re-

ported and can be relieved by treatment with hormones in a manner comparable to the treatment of such symptoms in the woman. The term "involution melancholia" is used to describe pathological depression occurring for the first time in the late fifth or sixth decade of life, but its symptoms are much the same as those of manic-depressive psychosis in earlier life. Most of the emotional disorder in men at this time of life can be attributed to a reluctance to accept the inevitable decline and death which are the lot of all men in this life of probation. At this stage of his career, a solid conviction of his true nature and supernatural destiny, together with the habit of prayer and the use of the Sacraments, are of untold help in growing old gracefully.

## CHAPTER FOUR

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# NORMAL CONCEPTION, PREGNANCY AND LABOR

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### CONCEPTION

AS HAS BEEN pointed out in a previous chapter, ovulation occurs about two weeks before the expected date of menstruation. The ovum is extruded from the surface of the ovary into the neighboring area of the abdominal cavity. In the meantime, the spermatozoa, having been deposited in the vagina, have entered the cavity of the uterus through the cervical canal and have gone through the Fallopian tube and entered the general peritoneal cavity. Somewhere between the ovary and the fimbriated end of the tube, the ovum is met by the spermatozoa, and one spermatozoon penetrates the ovum and unites with it to make a single cell. This event is conception, and the newly formed cell is a human being.

The impregnated ovum then migrates toward the fimbriated end of the tube and enters the tubal canal. It is then carried by cilia (motile hairlike parts of the tube's lining) through the tube and finally enters the cavity of the uterus, where it becomes embedded in the inner wall of the uterus and begins its further development.

It may be well to mention here that a patient who has had one tube and one ovary removed surgically, can still become pregnant; the remaining tube and ovary, moreover, would not necessarily have to be on the same side — the ovary might be on the right and the tube on the left, or vice versa. We have operated on one patient for prolapse a few years after delivering her of two children and found that she had a congenital absence of both tube and ovary on one side.

As the fertilized ovum develops, it assumes the form of a fluid-filled sac, the shell of which is the amnion already described. From one point of the amnion a stalk protrudes into the amniotic fluid; and at its free end is the growing embryo, attached to the stalk at the umbilicus or navel. At the point where the stalk, technically called the umbilical cord, is attached to the amnion, the placenta develops. This is a structure which at term is six to eight inches in diameter and one to two inches thick at its center and is composed of maternal and fetal tissue. Arteries and veins from the fetus carry the child's blood back and forth between the fetus and the placenta. In the placenta the fetal blood vessels are in contact with the lining of the maternal blood spaces developed by the uterine lining (endometrium), the beginning of which has been described in Chapter II. Here oxygen and food products are acquired from the maternal blood, and carbon dioxide and waste products from the child are discharged into the maternal blood. These duties are taken over by the lungs and kidneys, and, to a lesser extent, by the bowels and skin of the child after birth. During pregnancy the burden of the two persons must be borne

by the mother's organism, a fact to be remembered in the consideration of pregnant women with impaired hearts, lungs, or kidneys.

It has been pointed out that ovulation is controlled by hormones, principally those of the pituitary gland and the ovary. The pituitary gland secretes certain hormones which are designated as prolan "A" and prolan "B." Even today, after intensive investigations, it is not possible completely to differentiate the relation of these hormones to each other. It is enough to say that they have a stimulating action on the ovary, which as a result, emits other hormones called estrin and progestin, whose function is to prepare the cavity of the uterus for nidation (that is, to make a nest or resting place for the embryo) if pregnancy is to occur. If pregnancy does not occur, these ovarian hormones, estrin and progestin, cause certain changes to take place in the lining membrane of the womb preparatory to menstruation (that is, the throwing off of the lining membrane of the womb), and the menstrual cycle continues. If pregnancy does occur, one of these hormones, progestin, controls the action of the corpus luteum (now occupying the site of the ovum before its expulsion), giving it an inhibitory action which changes the lining membrane of the womb so that instead of being thrown off, the membrane is prepared to serve as the resting place for further development of the ovum. Certain layers of the uterine lining are formed which are called the decidual layers, and ultimately these cover every part of the inner surface of the womb.

One of the best scientific tests to determine pregnancy is the Aschheim-Zondek test, better known perhaps as the



rabbit test. This consists of the injection of the blood or urine from the patient into a virgin rabbit. After from six to forty-eight hours, depending on the modification of the Aschheim-Zondek test that may have been done, the rabbit is "put to sleep" and the ovaries examined. If the patient is pregnant, the urine or blood so acts on the ovaries of the rabbit as to cause certain changes that cannot be caused by the blood or the urine of a patient not pregnant. We consider the test or its modifications 98 per cent accurate.

### ABDOMINAL, BREAST, AND OTHER BODILY CHANGES

The female bony pelvis is divided anatomically into two parts, one called the false pelvis and the other the true pelvis. The false pelvis may be described as that part of the bony pelvis that can be felt by making an exterior abdominal examination and the true pelvis as that part which is felt by examination through the vagina or rectum. At the end of the third month of pregnancy the uterus has increased sufficiently in size to fill the pelvis up to about the lower level of the false pelvis. From that time on, it continues to grow in size, so that at the end of the fifth month the top of the uterus is at the level of the umbilicus (navel) and at the end of the seventh month it is at a point midway between the umbilicus and the ensiform (the lower tip of the breast bone). From the seventh month on, the uterus continues to enlarge in every direction, so that from about the eighth month to the middle of the ninth month it is not far from the tip of the ensiform. During the last

few weeks of pregnancy the uterus may appear smaller in size than was previously the case because the presenting part of the baby (which is usually the head) begins to descend into the lower pelvis, making the size of the uterus appear smaller (because of the top being lower), although it is really larger. The structure of the uterus is mostly muscle fiber and connective tissue, a combination which allows the uterus to grow larger as the fetus increases in size.

The baby is encased in the amniotic sac, and the amnion secretes a watery fluid called the amniotic fluid. Since every possible cubic centimeter of the uterine cavity is occupied by the baby and the amniotic fluid, the growth of the uterus occurs in every direction, upward, downward, forward, backward, and toward each side. This mode of enlargement follows a simple law of physics — that enclosed fluid exercises an even pressure in every direction.

Changes which ultimately allow a small degree of mobility of the pelvic joints and changes in the whole skeletal structure and in the soft parts, which make it appear as if there has been enlargement of every part of the body, also take place. To the casual observer the enlargement is especially evident in the face. Within a few weeks of the time the baby is born, these changes, presumably because of hormone action, disappear, and the skeletal structure and soft parts become as they were previous to the beginning of a pregnancy.

Remembering that the abdominal cavity contains besides the uterus, tubes, and ovaries still other structures — the liver, the spleen, two kidneys, the pancreas, the stomach,

and about thirty-three feet of intestines — one can readily understand why there should be digestive and metabolic disturbances, since all of these other organs are being crowded or pushed out of their normal positions by the constantly increasing encroachment of the enlarging uterus. This should explain the bowel disturbances (constipation, for example) which may be expected because of the pressure of the enlarging uterus on the large bowel and the occasional discomfort from eructations of gas, since the pressure makes it more difficult for the stomach and intestines to act as they would if the patient were not pregnant.

**The Bladder.** The back wall of the bladder is attached to the front wall of the lower uterine segment and the cervix of the uterus. This attachment subjects the bladder to pressure and “pulling” by the constantly enlarging uterus, with resultant urinary disturbances. As the baby increases in size and the presenting part (which is usually the head) presses on the bladder, there may be other urinary disturbances, especially frequency of urination.

**Pyelitis.** There is a distressing complication of pregnancy called “pyelitis,” an inflammation of the pelvis of the kidney. Although there is no unanimity of opinion as to the *true* underlying cause of pyelitis, all urologists agree that it is an infection and that pressure of the constantly growing uterus on the ureters (ducts from kidneys to bladder) can be an exciting factor. Since there is a direct lymphatic connection between the right kidney and the colon, we have a plausible explanation for the cause of some cases of pyelitis, especially those in which the exciting organism is the colon bacillus.

**The Sacroiliac Joint.** The joint that is formed on either side of the pelvis posteriorly by the lower part of the spinal column and the back part of the pelvic bone is the sacroiliac joint. If there is any normal mobility of this joint in the nonpregnant state, it is so slight as to be almost negligible. As pregnancy advances and Nature is preparing the pelvis for the birth of the baby, the mobility of the sacroiliac joint increases slightly. With the stretching of the ligaments that help form this sacroiliac joint, there may be at times considerable backache, which in the majority of cases yields readily to a properly fitted corset. Simple medication with the salicylates may also be beneficial.

**The Breast.** Constant changes are taking place in the breast, preparing it for lactation. These changes are doubtlessly inaugurated by hormones. From week to week the breast becomes larger, and although some secretion is possible from the very earliest days of pregnancy, this phenomenon usually does not occur until the latter weeks. Although it has not been definitely proved, it seems to be a plausible theory that with the expulsion of the placenta (afterbirth) at the time of the delivery, further changes in the hormone system result in the beginning of a free secretion of milk from the breast gland.

It is well to mention here that, also because of hormone actions (or non-actions), a woman does not as a rule have an early return of menstruation if she nurses her baby. It has been proven, however, that the absence of periods does not necessarily mean the absence of ovulation. While there may not be ovulation in the early months of lactation, and doubtless is not, there is usually at least one ovu-



lation before the re-establishment of periods. Where there is ovulation, there is also the possibility of impregnation. This explains why it is possible for a patient to become pregnant again some four, five, or six months after the birth of a baby without having had an intervening menstrual period. Menstruation is usually established in the nursing mother about nine months after the birth of the baby, but occasionally shows itself some few months earlier or later. When this first menstruation occurs, many physicians recommend the weaning of the baby, that is, taking the baby off the breast entirely. No one has yet been able to prove in the laboratory that there is a marked change in the chemistry of the milk with the return of menstruation, but at approximately nine months the average baby is usually so well developed that further breast feeding might lower the vitality of the mother, while artificial feedings, properly administered, will suffice for the baby.

Regardless of the marked advances that have been made in artificial feeding, the best food for the newborn baby is what Nature intended it to be — mother's milk. We also believe that the best way to reduce the infantile mortality rate further is to encourage every mother who can to nurse her baby. If a mother takes proper care of her nipples and follows a proper regime as to living, her general health is affected beneficially rather than adversely by nursing her baby. If, however, we consider a patient "under par" and believe that breast nursing might further lower her vitality, we do not hesitate to advise a mother not to nurse her baby.

**Nature's Birth Control.** In recent years much has been said and even much more written about so-called "birth



control." We do not like the term, but most certainly prefer it to "birth prevention." We hear much of "planned parenthood" and the "spacing of children." If a mother, for reasons of health or for any other reason, does not wish to have a baby whose conception might take place only a few months after the date of the previous birth, there is less likelihood of her becoming pregnant if she nurses her baby for some few months than if she gives it artificial feeding. It is to be borne in mind, however, that in rare cases ovulation returns in the nursing mother only a few months after the date of the previous birth and that there can be one ovulation before the first menstruation.

## LABOR

Until recently it was thought that normal pregnancy lasted 280 days. Even long before the advent of the rhythm theory, it was occasionally possible to determine the exact date on which conception took place, and it was found that these patients delivered nearer 265 days after the date of conception than 280 days. Since in many animals menstruation and ovulation are synchronous, it has been easy to determine the duration of pregnancy in the cow, the mare, the elephant, and other animals. It was not easy to accurately determine the length of pregnancy in the human female. Now that it is indisputably settled that ovulation in the human takes place 12 to 14 days before what will be the date of the next period if pregnancy does not take place, it is possible to determine fairly accurately in the woman with a regular cycle the duration of pregnancy. Since it

is biologically impossible for a woman to become pregnant except during the so-called "fertile" period and since we know that ovulation takes place at a fixed time, it is easy to determine when a fetus in the uterus is viable and when the date of birth may be expected. It is our opinion that the time of viability of a baby (26 weeks) should be reckoned from the date of probable ovulation and not from the date of the first day of the last menstrual period. It is our opinion, too, that the date of viability should be considered as standard, and we do not agree with those writers who say that a child may be considered viable at 26 weeks if it is to be delivered in a hospital and at 28 weeks if it is to be delivered at home. If a 26-week old fetus has a chance to survive, and we firmly believe that it has, that chance should be just as good at home, if the child is properly cared for, as at a hospital. In a busy clinic like that of one of us, the question of the date of viability arises frequently, and that date is reckoned from ovulation time and not from the date of the last menstruation.

We do not know for an absolute certainty just why labor starts when it does. The most plausible explanation is that there is a hormone control, possibly by the pituitary, which starts the uterus contracting. Labor begins when the fetus has matured and this condition is usually spoken of as "maturation of the fetus." We know that labor starts when the fetus has developed sufficiently in the uterus to live and thrive once it leaves the mother's womb and is delivered.

**Miscarriage.** Although the theory of periodicity has rightfully been discarded as the reason for a patient falling

in labor, it is nevertheless true that a pregnant patient is more apt to miscarry at the time she would be menstruating were she not pregnant than at any other time. The subject of miscarriage is discussed in Chapter V.

**Mechanism of Labor.** Since the medical facts in this book are written for the clergy rather than for physicians, it appears better to describe the mechanism of labor in language and in style easily understood, even if the description is not "academic."

When one considers the possible need of delivering a patient by cesarean section, rather than through the normal birth canal, he speaks in terms of passage and passenger. He tries to determine whether the passenger (the baby) is of a size which will allow it to negotiate the passage (the birth canal).

As previously stated, the female pelvis may be described as consisting of two parts, the false pelvis and the true pelvis. The hip bones that one can easily feel on a superficial abdominal examination are, to be sure, important parts of the female pelvis, but for obstetrical purposes they are described as the false pelvis. The inlet of the true pelvis is spoken of obstetrically as the "superior strait." If the inlet of the pelvis happened to be a true circle, which it is not, a description of the mechanism of labor would be made much easier. The *inlet* may be described as being elliptical rather than circular. Being elliptical, it can be readily understood that its diameters are not equal in every direction. Let us define the pelvis as having an anteroposterior diameter, from front to back in the middle of the pelvis, a lateral diameter, from one side to the other, and of neces-

sity, oblique diameters. In an attempt to make the mechanism of labor easily understood, let us remind our readers that it is very easy to place the foot into a shoe and then properly lace the shoe, but it would be an absolute impossibility to place the foot in the shoe in any but an anteroposterior diameter, that is, from toe to heel. Likewise, it is impossible for the baby's head (because of its size and shape) to enter the inlet of the pelvis in any but the oblique diameter.

Now let us consider the *outlet* of the pelvis. It is impossible for the baby's head to leave the outlet of the pelvis except through the anteroposterior diameter. This being so, it should be evident to any reader that certain mechanics (known as the mechanism of labor) must take place during the descent of the baby's head through the birth canal, when it must of necessity enter the pelvis in an oblique diameter and leave it in an anteroposterior diameter. What the head does, so must the rest of the fetal body. It, too, must change its course during its descent through the birth canal from one diameter to another.

Let us visualize for a moment a small boy attempting to gain entrance to an orchard surrounded by two fences. The outer fence is about three feet distant from the inner fence. The boy notices that the pickets of the outer fence are so arranged that it is possible for him to project his head between two of these pickets. Having done so, he realizes that he cannot get his shoulders to follow his head unless he turns his body in such a manner as to have the shorter diameter of his shoulders and chest go between the same pickets. The outer fence had pickets arranged vertically

and the boy has already succeeded in getting through it. He still has an inner fence to negotiate. The pickets of this fence are arranged longitudinally. He simply turns his body to that position that makes it possible and easy for him to penetrate the inner fence with his head in the right diameter, and then to turn his shoulders in such a manner as to make it possible for him to project his whole body through the fence, thereby succeeding in entering the orchard. To be sure, all the time the small boy was faced with mechanics, but, nevertheless, he finally succeeded in accomplishing what he set out to do. And labor is very much the same as the boy entering the orchard surrounded by two fences, one with vertical pickets and the other with longitudinal pickets. The fetal head naturally finds its way, because of uterine contractions and intrauterine pressure, to the oblique diameter of the inlet and, after it has negotiated or passed through this oblique diameter, follows the course of least resistance and turns in such a manner that it can leave the pelvis in the correct diameter (anteroposterior). The rest of the baby's body follows a like course. The difference between the boy going through the fences and the baby going through the birth canal lies in the fact that the boy pushes himself through, while the mother has to push the baby through. Since this involves considerable hard muscular work, the process has received the very descriptive name of "labor." The labor pains are caused by the extremely strong contractions of the uterine and abdominal muscles.

The pain of labor can be considerably lessened by proper medication. In fact, it is possible in numerous instances



for a patient to suffer so little that she doubts that she is really in labor. So great has been the advance in recent years that it is possible by proper medication with barbiturates, or other drugs, and by analgesics and the numerous safe methods of anesthesia, for a patient to give birth to a baby with but little suffering. It is possible, too, by the proper use of amnesics, for a patient to give birth to a baby and have no recollection of the birth of her baby, even if she suffers greatly from labor pains. We realize that there has been at least some discussion about the propriety of the physician using barbiturates, analgesics, amnesics, and anesthetics to help the patient in labor. We are of the opinion that not only are such practices proper, but that such treatment should be given every patient in labor unless by chance there is some organic condition on the part of the mother that militates against it. It is our opinion that one very good way to discourage planned parenthood and birth prevention is to make it possible for the mother to have an easy labor. When barbiturates, etc., are properly administered, there is no danger to either mother or baby and no moral objection to their use.

## COMPLICATIONS OF PREGNANCY

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### NAUSEA AND VOMITING OF PREGNANCY

WE INTRODUCE this subject, not because the condition is any longer considered a good reason for inducing abortion (by those physicians who advocated such treatment), but to give some evidence for our contention that abortion is not even good medical treatment for it.

To put it conservatively, fifty per cent of all pregnant women suffer at one time or another during their pregnancies from both nausea and vomiting technically termed hyperemesis gravidarum and commonly called morning sickness. In ninety-five per cent of all cases these symptoms occur during the first three months of pregnancy. Their severity varies from very mild (so mild, in fact, that the patient would not mention these symptoms were she not asked about them) to very marked. Nausea and vomiting of pregnancy may be classified as being either (a) physiological or (b) pernicious (pathological). A case may be looked upon as being of the physiological type until that time when due to an acidosis (an impoverishment of alkalines) acetone and diacetic acid make their appearance in

the urine. Then the case must be looked upon as pernicious (pathological).

There is but little likelihood of any physiological case becoming pernicious if the symptoms are properly treated from the start. For simple nausea and vomiting of pregnancy it usually suffices to regulate the diet, stressing the fact that a high carbohydrate diet will in all probability do much toward clearing up these distressing symptoms.

The patient is encouraged to take freely of simple, sweetened drinks and to eat plenty of bread, potatoes, cereals, desserts, etc. She is also encouraged to increase the usual amount of sugar taken in her tea or coffee. It is common-sense treatment to advise the patient to eliminate from her regular diet those foods which she knows from previous experience disagree with her and to eliminate also such foods as her common sense should tell her not to take. She should be admonished to take excellent care of her bowels and see to it that they move at least once a day. She should drink plenty of water, thereby aiding in the elimination of toxins.

Up to fairly recent times nearly every textbook has classified nausea and vomiting of pregnancy as being either a neurosis or a toxemia. Today there are few who teach that neurosis plays any part in the etiology of nausea and vomiting of pregnancy except in those cases where a patient has always been even before marriage, or as a child, of the neurotic type — that type who may force herself to vomit in order to excite the sympathy of her husband or to convince those around her that she is really sick. We do not

look upon a case as being neurotic when the neurosis is entirely volitional.

If hyperemesis were a *true* neurosis, we would expect it to be an outstanding sign or symptom in those unfortunate girls who are illegitimately pregnant. In some of these cases the illegitimately pregnant girl tries to conceal the pregnancy from her family and friends by "refusing to vomit" or to complain of nausea.

Nausea and vomiting usually subside at about the end of the third month of pregnancy, and this is about the time that the placenta exists as a distinct entity. Does the placenta secrete some hormone which has a beneficial tendency toward relieving this distressing symptom? Possibly it does, but we cannot name it, nor, to our knowledge, has it yet been isolated. Many teachers and obstetricians advise the use of corpus luteum extract in such cases, and although the results are not always satisfactory, we consider it good judgment to use it, especially in refractory cases.

Sedatives should be administered in some cases. Since morphia is re-secreted into the stomach, thereby helping to keep up a vicious cycle, we rarely use it in such cases. If sedation is indicated, bromides or a barbiturate are preferable to an opiate. Very essential is a high carbohydrate diet with forced fluids, so that everything possible is done to thwart the appearance of either an acidosis or a pronounced toxemia. Proper vitamin intake, especially of vitamin B-1, is also very essential.

A malposition of the pregnant uterus may possibly aggravate nausea and vomiting, if it does not actually

cause them (a good example of a "reflex" cause). This being so, it is well to examine every patient, and to correct malposition, if there is one, and insert a pessary if needed to prevent the uterus from retroverting again. Some obstetricians are of the opinion that a retroverted uterus will take care of itself if left alone, but we disagree and strongly advocate replacing the uterus into its normal position. Usually this can be done in the doctor's office and without an anesthetic; rarely is it a hospital case with anesthesia. If, however, a uterus has developed to such a size that it has become incarcerated, that is, locked in the lower pelvis, and it is very difficult to free it from its incarceration, it is well to hospitalize the patient and do the replacement under anesthesia. After the third month the uterus has become so large that it is impossible for it to fall back into the pelvis again and become incarcerated.

It is of interest to relate that one of us was told years ago by a very brilliant internist (now dead) that he had wonderful results in treating cases of nausea and vomiting of pregnancy with arrowroot tea. We used it in several cases with considerable improvement. We know now that its efficacy was due to its being a starch and that any other like carbohydrate would have given the same good result.

We were using a placental extract made for us by Parke Davis and Company as far back as 1913, long before hormone treatment really became the vogue. This treatment was prescribed because of the fact that the symptom decreased in severity at the end of the third month, this being the time that the placenta as such exists as a distinct entity. We suspected then that the functioning of the whole



placenta might have some relation to the amelioration of the symptoms and consequently decided to give placental extract in the early months before the placenta did exist as a distinct entity.

Occasionally, a case of physiological nausea and vomiting of pregnancy will not respond to simple treatment, and acetone and diacetic acid then appear in the urine, thus making the case no longer physiological but pathological (pernicious). What are we to do for this type of case? The patient should be hospitalized, all food by mouth should be prohibited, and she should be given glucose and saline intravenously. One should give 1500 cubic centimeters to 2000 cubic centimeters of a 5 per cent glucose solution in water or saline every day, and with the glucose some advocate the giving of insulin, 10 units in the glucose solution and 20 units about one-half hour after the intravenous injection has been finished. While the intravenous treatment is being given, nothing should be taken by mouth except just enough water to keep the mucous membrane of the mouth moist. Acetone and diacetic acid will disappear quickly under this treatment, and when all sense of nausea and retching have disappeared, the patient may be given "high carbohydrate" liquids by mouth, a few ounces every hour while the patient is awake. When it has been demonstrated that the high carbohydrate liquid diet is well tolerated, a high carbohydrate liquid and soft solid diet is given, to be followed in twenty-four hours with a high carbohydrate "house diet." Since in these pernicious cases there is always a deficiency in chlorides and serum protein, both should be given in conjunction with the high carbo-

hydrate diet. They may be treated with various hormones, with sedatives, vitamins, and so on, their use being much more necessary than would be the case if the condition were physiological rather than pernicious.

Before our present knowledge of the treatment of pernicious vomiting there were many obstetricians who advocated therapeutic abortion for this condition. It is sad to relate that even today there are some few physicians who still recommend performing a therapeutic abortion as a cure for this disease. What is a therapeutic abortion? The emptying of the uterus by instrumentation of its contents, its contents of course being a live fetus. As is well known, it is not licit to do any operative or other maneuver that would result in the expulsion of the child from the cavity of the uterus unless twenty-six weeks have elapsed since the date of conception, and to our minds the date of conception should be reckoned not from the first day of the last menstrual period but from the date of ovulation.

The ethics and morality of cases of this type have been covered so many times in other chapters that it seems hardly necessary to state that the Catholic Church does not sanction therapeutic abortion. The Fifth Commandment is: "Thou shalt not kill"; and no one will argue that human life does not exist in the fetus in utero.

#### ANTEPARTUM BLEEDING

The term "antepartum bleeding" refers to hemorrhage from the uterus during pregnancy, that is, from the time of conception to the actual birth. It may occur at any

period of pregnancy, but it is best for our purposes here to consider bleeding from the time of conception to the date of viability, which is 26 weeks after conception, and bleeding from the period of viability up to term.

The causes of uterine bleeding before the period of viability may be listed as follows:

1. Trauma of External genitalia or vagina.
2. Endocervicitis.
3. Submucous polyp.
4. Cancer of the cervix.
5. Fibroid uterus.
6. Miscarriage.
7. Placenta praevia.
8. Premature separation of the placenta.
9. Cancer of the body of the uterus.
10. Rupture of the uterus.
11. Ectopic pregnancy.

**Trauma of the External Genitalia or Vagina:** Trauma (mechanical injury) of the external genitalia and vagina may be repaired in the pregnant as in the nonpregnant woman. We refer to injuries caused by automobile accidents, falls, and similar accidents.

**Endocervicitis:** Endocervicitis is an inflammation of the cervix of the uterus, that is, the part of the uterus which protrudes into the vagina. This inflammation is usually around the external os, which is the beginning of the cervical canal. It may cause slight bleeding before the period of viability and can be treated by local applications. In the nonpregnant state many cases are best treated by

diathermy or with the actual cautery, but during pregnancy such treatment may possibly cause a miscarriage and, therefore, is better not used. Of course, if the endocervicitis were of such a serious nature as to constitute a proportionately grave and imminent threat to the mother's life, which is most unlikely, the principle of the double effect can be invoked and the cautery or diathermy used. At the cost of repetition and merely for emphasis, let it be repeated that the likelihood of an endocervicitis ever being severe enough to require such treatment is extremely small.

**Submucous Polyp.** A polyp is a growth of varying size which is attached to a surface, either external or internal, of some bodily organ by a small stem called a pedicle. In the condition referred to here, a submucous polyp is one which is attached by the pedicle to the lining membrane of the uterus or cervix. Whether or not it should be removed depends upon its size and position and the amount of bleeding. If the polyp is not bleeding or causing any other threatening symptom, it should always be left alone. If there is bleeding and if the pedicle is attached to the cervix but not in the canal and can be removed without serious danger and without the expectation of having the removal cause abortion, it should be removed according to both medical and moral principles.

If the polyp is cervical with the pedicle attached to the canal of the cervix somewhere between the external os and the internal os and is causing bleeding, and if the cervical canal is patulous (open) enough to make it possible to remove the polyp without coming in contact with the fetal sac, it is licit to remove it. Such a case is more likely to be

present in the multipara, (that is one who has had one child or more) whose cervix has been lacerated as a result of previous childbirth, thereby tending to make the os patulous. We have never seen a submucous polyp in the cervical canal of a primipara, and if we did, we would not find the os patulous and it would be neither easy nor safe to remove the polyp. In this hypothetical case, which in our experience we have never seen, we would not attempt to remove the polyp surgically unless the amount of bleeding warranted it (and the probability of the bleeding threatening the patient's life is almost nil).

If, on the other hand, one discovers during the course of an examination that there is a polyp present which is not causing bleeding, there is no reason or indication to remove it. A patient can have a polyp without any untoward signs or symptoms. If there should be slight bleeding and one is not certain that he could remove the polyp without possibly doing harm to the ovum (the embryo or fetus), the polyp could be treated by local applications, for example, silver nitrate or tincture of iodine, which might possibly result in the polyp sloughing off and taking care of itself. We have used both preparations in numerous cases and have never seen either act deleteriously.

In some cases a polyp is found with the pedicle located between the wall of the uterus and the fetal sac and attached to the lining of the body of the uterus at some point, high or low, and not visible to the examiner. In this type of case, the removal of the polyp and pedicle would necessitate a certain amount of separation of the amniotic sac from the wall of the uterus, as well as some dilatation of the



mouth of the uterus, an operation likely to precipitate labor pains and abortion. Invariably, such a polyp does no harm and can be left alone. If a polyp of this type were causing sufficient bleeding to warrant operation, we would do no more than tie off the pedicle at a point just outside the external os of the cervix, and then remove the base of the polyp. It must also be remembered that as the pregnancy advances and the uterus increases in size, pressure of the constantly growing ovisac may so interfere with the circulation of blood in the polyp by causing pressure on the pedicle that the polyp may — following the normal laws of nature — disappear, in other words, take care of itself.

Solely for the purpose of being informative, we will state that in many, if not in most instances, bleeding from a cervical polyp is aggravated by coitus, hence the need of local treatment in many cases.

**Cancer of the Cervix.** Cancer of the cervix of the pregnant uterus is rarely encountered. The outstanding symptom is bleeding. A vaginal examination and examination of a small fragment of tissue taken from the cervix quickly confirms the diagnosis. Cancer of the cervix may already exist at the time of conception, or may have its inception after pregnancy has started. There should be no so-called "palliative" treatment for cancer of the cervix. Prompt treatment is indicated. If, however, the diagnosis of cancer of the cervix has not been made until a few days previous to the time the baby would be viable, treatment might be postponed until the date of viability.

Today, cancer of the cervix in the nonpregnant patient is treated by radium and deep x-ray, by operation, or by a

combination of both. Each treatment has its champions. There are those who feel that radium and x-ray is the best treatment, and there can be absolutely no doubt that such treatment is not only the best treatment but the only sane treatment for advanced cases. Long before the use of radium and deep x-ray for this condition, cancer of the cervix was treated by performing a hysterectomy which consisted of removing the entire uterus, the tubes, the ovaries, the uterine ligaments, all palpable or visible glands, and so forth. There are those who today advocate the operation in supposedly early cases, but the determination of whether a case is "early" or "advanced" is a question too academic for our purposes here.

For cancer of the cervix in a nonpregnant patient, we favor treatment by a roentgenologist with radium and deep x-ray. In the early months of pregnancy, however, we feel that the better treatment is by operation, all the pelvic organs being removed with the fetus still in the uterine cavity; to our minds this operation is an outstanding example of the indirect voluntary.

We perform the hysterectomy to remove an organ invaded by a malignant disease. Let us make it very plain; we are not primarily attacking the fetus. We would not remove the fetus from the uterus until after the organ had been removed. Fortunately, such cases are rare, but when one is met, if the patient is a Catholic, the specimen is quickly opened and the fetus is baptized. If cancer of the cervix is found in a patient at a date following viability, we recommend delivery of the baby by cesarean section and then a complete hysterectomy, if possible. The anatomy,

the physiology, and the circulation of the uterine organs are so altered by pregnancy that we would prefer not to treat such a patient with radium and deep x-ray therapy. For the purpose of surgical information we will say that in every case of cancer of the cervix in either the pregnant or nonpregnant state which has been treated by hysterectomy, we consider it good judgment to follow up the surgery with x-ray treatment.

Let us consider for a moment what we will describe as a very advanced case of cancer of the cervix complicating pregnancy with the baby viable. We would deliver the baby by cesarian section, and if we found that the extension of the cancer was so great that it would be impossible to remove the uterus without possibly sacrificing the life of the mother, we would close the abdomen and treat such a case as best we could with radium and deep x-ray. As stated previously, cancer of the cervix is fortunately a rare complication of pregnancy and fortunately, too, advanced stages are still more rare. If and when a Catholic physician is confronted with such a case his treatment would necessarily depend on how extensive the process is; but he should bear in mind that it is licit to remove the uterus even if the child is not viable, and that it is licit, too, for his treatment to be wholly by radium and deep x-ray if he thinks he can get a better result than by surgery.

**Fibroid Uterus.** Fibroid tumors are benign tumors of the uterus which are met with occasionally as a complication of pregnancy. These tumors may cause hemorrhage, or they may increase to such a size that they interfere greatly with the development of the fetus in the uterus.

There may be a single fibroid tumor in the uterine body, or there may be a dozen or more. A fibroid tumor may vary in size from that of a small marble to that of a baseball or even a basketball. The location of these tumors may be such as to cause no encroachment on the cavity of the uterus or, conversely, to cause considerable pressure and distortion on the cavity of the uterus. If in a routine examination of the pregnant patient a fibroid condition is found which is causing no serious symptoms, it is well to leave it alone, the patient being carefully observed at every prenatal visit. If there should be considerable bleeding or if there should be other serious signs, operation and hysterectomy may have to be performed, even though the fetus is not viable. If such a condition arises, it is licit, according to the principle of the double effect. Again, we stress the fact that the hysterectomy must be done with the fetus still in the uterus. Again, immediately upon its removal, the diseased organ is opened and the fetus removed. If it is plainly apparent that baptism cannot be postponed until the arrival of the hospital chaplain, the operator or an assistant or nurse should immediately confer the sacrament. Fortunately, such cases are rare but, nevertheless, more common than cancer of the cervix. If a pregnant patient with fibroid tumors has reached the stage of viability and operation is necessary, the baby may be delivered by cesarean section; and whatever else is to be done may be determined by the condition of the organ at the time of operation.

Over the years we have seen a few pedunculated sub-serous fibroid and a few sub-serous tumors that were not



pedunculated which were causing symptoms severe enough to warrant operation. Most of these were before the age of viability. We were able to remove the tumors without the patient miscarrying. Whereas such operations are licit, it is well to bear in mind that they should not be performed unless the indication for operation is absolute, lest there be a miscarriage.

Over the years we have seen as a complication of pregnancy quite a few cases of pedunculated sub-serous fibroids and also sub-serous tumors that were not pedunculated. (The sub-serous layer of the uterus is the outer layer — the layer that one sees when the abdomen is opened.) In most instances these tumors caused no trouble, either during pregnancy or labor. Some of them, however, did cause considerable pain with a rise in temperature, vomiting, etc. and with all the symptoms increasing in severity from hour to hour rather than abating under conservative non-surgical treatment. In the pedunculated group, one must consider the possibility of the pedicle being “twisted” with a resultant interference with the circulation and in the sub-serous group the possibility of rupture of the wall of the uterus or an inflammatory action without rupture. The surgical picture in those patients whose symptoms show no sign of abatement but, on the contrary, an increase in severity may well be described as the “acute abdomen,” implying that there is sufficient cause to open the abdomen and to do whatever surgery is necessary, licit and safe.

We have operated a few such cases, one with the baby viable and the others before the arrival of the date of viability. All did well and none miscarried or gave birth



to the baby prematurely. It is our opinion that it is licit to operate such patients but we nevertheless advise that surgery be done only when it becomes evident that non-surgical treatment will not suffice and that not operating might conceivably result in the death of the mother, the fetus or both. It is our opinion, too, that such operation should be performed only by well-trained and experienced gynecologists or obstetricians and not by any general surgeon.

It will not be amiss to mention here the possibility of an ovarian cyst or tumor complicating pregnancy or labor to such an extent as to warrant immediate operation and removal. We have been compelled to operate a number of such cases and certainly a larger number than for fibroids complicating pregnancy. All but one of these were operated before the baby was viable, the indication being the acute symptoms caused invariably by a twisted pedicle and the desire to remove the tumor well in advance of the expected date of delivery when, if it had not been removed, it could cause serious complications and perhaps necessitate delivery by cesarean section. We have operated one such case when the patient was  $8\frac{1}{2}$  months pregnant. She entered the hospital as an emergency and was operated upon that same day. She had not been seen previously by a physician. She was a primipara, 18 years old and except for the large ovarian tumor was otherwise in excellent physical condition. Her pelvic measurements were adequate, i.e. were large enough to allow the birth of a baby through the natural passages if this large tumor was not causing an obstruction in the birth canal. Remembering

the dictum that the primipara who is delivered by a cesarean section may have to be delivered by cesarean section at all her deliveries — and the likelihood of such is greater in the primipara who has never had labor pains (contractions) — we decided to remove the large tumor and allow the pregnancy to continue to term, which would have been two weeks later. We felt certain that the fresh abdominal scar would in no way interfere with the delivery fourteen days hence. We found out we were correct in our opinion when we arrived at the hospital the next morning and were told that the patient had delivered herself of a large baby normally just a short while before and without any untoward incident. She and the baby were discharged two weeks later, she with the knowledge that the future babies could be delivered through the natural passages and that she would not have to be delivered by cesarean section.

**Miscarriage.** All textbooks classify miscarriages as (a) threatened, (b) inevitable, (c) complete, and (d) incomplete. Furthermore, textbooks classify the expulsion of a fetus from the cavity of the uterus, from conception to three months, as being an abortion, the expulsion of the fetus from the third month to the time of viability as a miscarriage, and the expulsion of the fetus from the time of viability to any date previous to the expected date of delivery as prematurity. We do not like the term “abortion,” since to our minds it has a connotation of criminality. We will call any expulsion of the fetus from the time of conception to the date of viability a miscarriage.

What is a threatened miscarriage? If in the early months of pregnancy it is obvious that a patient is having uterine

contractions with or without the presence of a small amount of staining, it is safe to assume that the patient is threatened with a miscarriage. Or if it is evident that amniotic fluid is being expelled from her vagina, it can be assumed that one is dealing with a threatened miscarriage.

We will consider first the patient who shows contractions, with or without slight staining. The treatment of this condition is complete rest, preferably in a hospital. Hormones, whose function it is to inhibit uterine contractions, are systematically given; and the patient is properly sedated. We prefer the barbiturates rather than morphia as sedation, but we are cognizant of the fact that many well-trained obstetricians use morphia instead of barbiturates. After a few days of proper treatment, either the threat of miscarriage has subsided or new symptoms have appeared which make the case appear as inevitable. What are these new symptoms? With the threatened miscarriage a pelvic examination would invariably show the cervix of the womb to be intact and the external os not patulous (open). If rest, hormones, and sedation do not quell the threat of miscarriage, the uterine contractions continue and, finally, changes take place in the cervix of the womb which show that miscarriage is inevitable. These changes would consist of an effacement of the cervix with a dilatation of the os (opening of the cervix). Once the cervix is effaced and dilatation has started, further dilatation is sure to follow as time goes on.

We would treat the inevitable miscarriage, however, identically as the threatened miscarriage is treated. We would make no attempt to empty the womb because of this

evidence of inevitability; we would wait for the patient either to miscarry completely or to expel the fetus, alone or with the sac intact, into the cavity of the vagina. Once a fetus or sac has left the uterine cavity and has been deposited in the vaginal cavity, we would not hesitate to remove it and confer baptism immediately.

A complete miscarriage is one in which the fetus and ovisac have been expelled. Nature having well taken care of the case of complete miscarriage, no further treatment other than rest in bed, and so forth, is indicated. It might be well to give such a patient an oxytoxic (a drug that causes the womb to contract) at regular intervals for a few days following the miscarriage.

An incomplete miscarriage is one in which the fetus has been expelled but the placenta or membranes, in whole or in part, are still within the cavity of the uterus. The retained placental tissue or the retained membranes of an incomplete miscarriage conceivably could be expelled naturally or with the aid of oxytoxics, but we consider it good treatment to remove them surgically by curettage as soon as possible after the expulsion of the fetus. This curettage could be "digital" or instrumental, preferably with a dull rather than a sharp curette.

There are those who advocate no instrumentation, curettage, or other operation in the presence of any infection. We do not adhere to this opinion. If there is a serious infection, we might remove the tissue digitally rather than instrumentally. Thanks to sulpha, penicillin, streptomycin, chloreomycin, and so forth, we see little serious infection today after a miscarriage.



Exciting causes of miscarriage may be classified as being ovular or maternal. By "ovular" is meant that the ovum itself may be the exciting cause. By "maternal" is meant that the cause is wholly on the part of the mother. Ovular causes may be either developmental or disease on the part of the ovum itself. The maternal causes may be either local or general. The local causes may be either a disease of the endometrium or possibly a malposition of the uterus. The general cause may be almost any general systemic disturbance which, because of its very nature, interferes with the proper development and growth of the fetus in the uterus, for example, certain infectious diseases, nephritic toxemias, hypertensive diseases, and so forth. These conditions are discussed elsewhere.

Antepartum hemorrhage after the fetus has arrived at the period of viability may be due to (1) premature labor, (2) placenta praevia, or (3) separation of the placenta. If the bleeding is due to premature labor, it is invariably almost negligible and needs no discussion. It might better be characterized as a "show" or staining, rather than bleeding.

We believe that under no condition should a pack be placed *within the os* of a patient who is still pregnant and whose baby has not reached the age of viability, since this would positively encourage contractions of the uterus, causing miscarriage or premature birth, which possibly would not have occurred if the packing had not been placed within the os.

**Placenta Praevia.** Placenta praevia is a condition in which the placenta (the after-birth) is abnormally situated (in front or ahead of the baby). If the placenta is situated



directly over the internal os, that is, the opening at the end of the cervical canal of the womb, the placenta praevia is classified as being central or complete. If the edge of the placenta is at the border of the internal os, the condition is classified as marginal placenta praevia. If the patient falls into labor with the necessary dilating of the internal os, it can be readily seen how a marginal placenta praevia may become a partial placenta praevia, that is, part of the placenta lies free over the internal os and part is still attached to the wall of the uterus. Likewise, a central or complete placenta praevia, that is, central or complete before the onset of labor, may become a partial placenta praevia as labor advances; that is, the internal os finally dilates sufficiently to tear itself away from a portion of the placental attachment, with the result that part of the placenta is still free of its attachment over the internal os and part is still attached to the lower part of the body of the uterus.

There may be antepartum bleeding from placenta praevia without labor ensuing, or labor may be almost simultaneous with the onset of the bleeding. A strong diagnostic point in so far as placenta praevia is concerned is that the bleeding is invariably painless. Also, if labor does start, there is more likely to be profuse bleeding during the contractions of the uterus (labor pain) than during the intervals between pain.

**Premature Separation of the Placenta.** This condition is also known as “*abruptio placentae*” or “*ablatio placentae*” and is nothing more than a premature separation of the normally implanted placenta. Many cases of premature separation of the placenta are due to a coexisting toxemia

on the part of the mother. A very few may be due to traumatic causes, and in some no real cause can be found. In contrast to the painless bleeding with placenta praevia, the bleeding with premature separation of the placenta is painful. This is a strong diagnostic point.

Whereas in placenta praevia the bleeding is more likely to be profuse, with premature separation of the placenta the bleeding is apt to be scanty, especially in the beginning. This is because the blood must separate the amniotic sac from the wall of the uterus and slowly "percolate" down toward the opening of the cervix before there can be external evidence of bleeding. Many times, bleeding is going on behind the placenta and continues until a clot is formed which is large enough ultimately to separate the placenta completely from its uterine attachment. This condition is spoken of as "internal concealed hemorrhage."

In the process of separating placenta and membranes from the wall of the uterus, the blood, acting as a foreign body, sets up a spasticity of the uterine wall, with the result that the uterus feels boardlike and tense. A patient with a premature separation of the placenta many times will be in pronounced surgical shock, the extent of the shock being out of proportion to the amount of visible bleeding. On the other hand, when there is shock accompanying a placenta praevia, the shock is in true proportion to the amount of bleeding. It must be borne in mind that there may be an extensive or complete separation of the normally implanted placenta with but little if any evidence of external bleeding, most of the bleeding being internal or concealed. Occasionally, the separation of the amniotic

sac from the wall of the uterus may take place quickly enough to have the amount of visible hemorrhage fairly profuse.

We feel that the best treatment for placenta praevia when the child is viable and the praevia is complete or central is cesarean section, regardless of the parity of the mother, (that is, whether it be the first pregnancy or the fifth pregnancy). We feel, too, that some cases of partial and marginal placenta praevia are best treated by cesarean section, but we realize that some may be delivered from below. The deciding factor invariably is the amount of bleeding. It can readily be seen in our description of a partial and marginal placenta praevia that as labor progresses, the presenting part of the baby, usually the head, can act as a tampon (pressure on the partial or marginal placenta), thereby reducing the amount of bleeding from both the placental and the uterine sinuses to a minimum. The individual obstetrician is best able to decide the treatment of each separate case of partial or marginal placenta praevia.

It should be borne in mind that when the question of cesarean section is raised, the parity of the patient becomes an important consideration. If a primipara (a para I) is delivered by cesarean section, it is a safe assumption that she must be delivered by cesarean section in future pregnancies. If, however, her parity is four, she may be delivered by cesarean section and still be able to have any future children through the normal passage.

The explanation of the above statement is as follows: labor may be described as a battle of forces; the uterus in

labor contracts, thereby giving force downward to the presenting part of the baby, the expulsive force; the uterine contractions must overcome the resistance of the neck of the womb, of the vagina, and of the introitus (the external opening of the vagina) and of the bony pelvis. When the forces of expulsion have overcome the forces of resistance, and that is true labor, the baby is born. If these forces of resistance have been overcome three times by the forces of expulsion and each succeeding time the resistance is less, one takes little, if any, chance that the uterus will rupture while it is contracting during the fifth labor, after the fourth done by cesarean section. The forces of expulsion have been overcome before, and they can be overcome again. But with the primipara (the first labor) the forces of resistance were never overcome. If, then, the wall of the uterus, conceivably weakened by the incision made in it at the time of the primiparous cesarean section, exerts too great an effort in overcoming the powers of resistance, it might rupture itself, and the death of both mother and baby conceivably could result.

We are equally strong for cesarean section being the method of treatment in every case of premature separation of the placenta, regardless of the parity, if the baby is viable; the type of delivery in future pregnancies would depend on the parity and the patient's general health.

We have done many cesarean sections on patients suffering from premature separation of the placenta, and we have never been compelled to do a hysterectomy immediately after the cesarean section because of the uterus not



properly contracting. We know of instances, however, in which very excellent obstetricians were compelled to do a hysterectomy because of faulty power of contractility on the part of the uterus. We would say then that each case has to be decided on its own merits, and that if the competent obstetrician does a hysterectomy, it is licit for him to do so. On the other hand it is foolhardy to do a hysterectomy in every case of premature separation of the placenta. In cases of this type and because of the extravasation of blood into the wall of the uterus, it is described as being plum colored. Some obstetricians recommend a hysterectomy whenever the uterus is plum colored, but we do not consider this radical treatment at all necessary.

It is well to state that there are some obstetricians who feel that because of the possibility of profuse hemorrhage and faulty contractility of the uterus, patients suffering from premature separation of the placenta and who have been delivered by cesarean section should also have the uterus removed. We have done many cesarean sections for this condition and we have yet to do a hysterectomy and, moreover, we have yet to see one patient not do well with the simple cesarean section. It is our opinion that each case should be decided on its own merits and that if the competent obstetrician feels that a fatality might result if he did not do an hysterectomy, it is licit for him to do so. It is also our opinion, however, that it is not good judgment to do a hysterectomy on every case, but only when competent obstetrical judgment deems it necessary in the individual case. It seems illicit to remove the uterus in every case by



following a general rule and neglecting the clinical picture in the individual case. The necessity of the removal must be demonstrable. We know of some obstetricians who recommend that a hysterectomy be done in this condition whenever the uterus is plum-colored, the discoloration being due to an extravasation of blood into the body of the uterus. We can say that some discoloration (plum-coloring) ranging in degree from slight to pronounced is visible in every case. Most certainly, we have seen it, but we have never done a hysterectomy and all of the patients have done well.

**Cancer of the Body of the Uterus.** The treatment of this condition is the same as is the treatment with cancer of the cervix of the uterus, which has been discussed in a previous section. Rare as is cancer of the cervix complicating pregnancy, still more rare is cancer of the body of the uterus.

**Rupture of the Uterus.** In an earlier paragraph we have mentioned the possibility of the uterus rupturing in labor following a previous delivery by cesarean section. A uterus may rupture in a given pregnancy also because of the fact that, owing to a previous hard operative delivery by forceps or internal podalic version (changing the presenting part from head to breech), the uterus had been slightly ruptured, the rupture being so slight, in fact, as to have been beyond detection. Then in a future pregnancy, because of the scar tissue that has formed as a result of the injury in a previous pregnancy, the uterus may rupture. Such a condition may have as outstanding symptoms hemorrhage and

shock, the amount of each depending on the location and the size of the rupture.

We feel that the only treatment for a ruptured uterus is an immediate laparotomy. One should expect a rupture in the last weeks of pregnancy, rather than in the early weeks. In nearly every instance it would be at a time when the baby was viable. But if, by chance, a definite diagnosis of a ruptured uterus with internal bleeding has been made, it is to our mind licit to operate on the principle of the indirect voluntary (or double effect). Invariably, the uterus in cases of ruptured uterus must be removed. Rarely, the rupture is such that it can be repaired and the womb left in the pelvis.

**Ectopic Pregnancy.** The ectopic pregnancy is one situated outside the cavity of the uterus. Classifications are (a) tubal, (b) ovarian, and (c) abdominal.

In previous chapters we have discussed the passage of the impregnated ovum through the tube into the cavity of the uterus for its nidation. Small as is the lumen of the tube, if it is a normal tube, the lumen is large enough to allow the passage of the impregnated ovum through it. If it is an abnormal tube, abnormal in structure or abnormal secondary to a disease, which would then classify it as pathological, it may not allow the passage of the impregnated ovum through its lumen, with the result that nidation takes place somewhere in the tube. Naturally, the structure of the tube is such that rarely is it possible for a tubal pregnancy to go to term. For purposes of description, tubal pregnancies are classified as to their position in the tube. If the tubal pregnancy takes place near the end of the tube, that

is, the part starting at the fimbriated end (the open end of the tube) it is called "infundibular." If it is in the narrow isthmus of the tube, it is called "isthmial." If it is in the inner end of the tube, where the tube enters the uterine cavity at the cornu of the uterus, it is described as being "interstitial."

Let us first state that in many cases of ectopic pregnancy the fetus dies in the early weeks, and that many times a diagnosis of tubal pregnancy had not been made. In the majority of cases, however, the fetus lives until that time at least when the ectopic pregnancy ruptures and it is extruded into the abdominal cavity. Very rarely a fetus will live even after its expulsion through the rupture in the tube into the abdominal cavity. We have seen one case of a fetus of about three months which was alive when removed from the mother's abdominal cavity.

If the tubal pregnancy is infundibular, that is, just within the fimbriated end of the tube, it may remain as such or it may be extruded back through the fimbriated end of the tube and invariably perish, but possibly the sac may attach itself to the intestine, the omentum, or any organ in the female pelvis and then become an abdominal pregnancy.

With an interstitial pregnancy the pregnancy may remain interstitial or in the early weeks may be extruded into the cavity of the uterus and become an intrauterine pregnancy. If the interstitial pregnancy ruptures, the fetus is extruded into the abdominal cavity.

If the tubal pregnancy is isthmial, the ovum develops until the structure of the tube, not allowing any further

“stretching,” ruptures, and the fetus is extruded into the abdominal cavity.

The history of a typical ectopic pregnancy is invariably as follows: A patient misses a period. She notices certain changes in her breasts. She may be bothered by nausea and vomiting; and if an Aschheim-Zondek (the rabbit test) is done, it will show that the patient is pregnant. A few days to a few weeks after the expected date of a period she stains slightly, but knows that the staining is not enough to be a normal menstrual period. She may have a soreness or a dull ache on one side of the pelvis. A pelvic examination might be negative or might show a slight enlargement of the uterus. If the one making the examination has had sufficient experience, it might even be possible for him to feel a mass (the ectopic pregnancy) on one side. The explanation for the slight enlargement of the uterus and the irregular staining is interesting. The condition is brought about for the following reasons: regardless of the pregnancy being outside the womb, the endometrium lining the cavity of the womb prepares itself for nidation; and even if the impregnated ovum never reaches the cavity of the uterus, there have been enough changes in the endometrium preparatory to expected nidation to cause the uterus to increase slightly in size, and the bleeding to be from this proliferation of endometrium inside the cavity of the womb. It happens many times that, when a patient presents herself at the doctor's office or at a hospital clinic, giving a history similar to the above, the diagnosis is missed; and in all sincerity a physician may recommend a diagnostic dilatation and curettage to find out the cause of the bleeding.



When he does the curettage, he sends the endometrium to the pathologist for an examination, and many times the pathologist will report that the specimen shows decidual cells but no chorionic villi. What are decidual cells and chorionic villi? They are cells that will never be found except in a case of pregnancy. In a true uterine pregnancy, if a patient miscarried and was then curetted, both decidual cells and chorionic villi would be found. But in the case of the ectopic pregnancy, decidual cells only would be found, the nature of the pregnancy preventing the formation of chorionic villi anywhere but at the site of the pregnancy and not in the cavity of the uterus. This is a very fine diagnostic point but a most important one.

Invariably, as time goes on, the tubal pregnancy ruptures and the question of procedure naturally arises. Most theologians are today in agreement that it is perfectly licit to operate an ectopic pregnancy, to operate even an unruptured pregnancy, the reason being that the tube is pathological and that one is operating to remove the tube and not to destroy the fetus. Again, we have the indirect voluntary (or double effect). Let us make it plain that one cannot, even for the desire to baptize the fetus, open the tube and remove the fetus and then remove the tube. The tube must be removed with the ectopic pregnancy still in the body of the tube, and then the tube may be opened and baptism given (See Bouscaren).

Tubal pregnancies are by no means rare, but abdominal pregnancies are very rare, and ovarian pregnancies still more rare than abdominal. In our practice we have had two cases of full-term ovarian pregnancy. Both mothers



survived after delivery: the abdomen was opened, then the ovary was opened, and the baby was delivered. Both babies were born dead. It was evident that one had been dead a matter of months. The second had died but hours before the time of the delivery.<sup>1</sup> Since these two ovarian pregnancies were at term, there was no moral problem involved.

We have had one case of abdominal pregnancy, and we consider it interesting enough to give a complete history.

Four-and-a-half months previously the patient had been admitted to the same service at the hospital with a history of having missed one period and then about two weeks later having started to stain, and had been staining for some few weeks previous to her admission. A vaginal examination was essentially negative, a diagnostic dilatation and curettage was ordered and was done, and tissue was removed and sent to the pathologist. Now,  $4\frac{1}{2}$  months later, the patient returned to the hospital with a definite tumor of her lower abdomen corresponding in size to that of a  $4\frac{1}{2}$ - to 5-month pregnancy. The patient stated truthfully that she knew this mass could not be a pregnancy because of the fact that for some time previous to her first admission to the hospital  $4\frac{1}{2}$  months before, there had been no marital intercourse except once a few days previous to her present entry. Immediately, her old record was obtained, and the pathological report read as follows: "There are decidual cells in the curettings but no evidence of chorionic villi." On that fact alone, a diagnosis of ectopic pregnancy was made, and an Aschheim-Zondek test was reported as being positive. It

<sup>1</sup>F. L. Good and T. K. Richards, "Ovarian pregnancy," *Surgery, Gynecology and Obstetrics*, February, 1923, pp. 239-241.

was not easy to decide how to proceed properly with the case, but finally we concluded that instead of the patient having had a dilatation and curettage, she should have had a laparotomy (opening the abdomen). We thought that the mass could be the result of a ruptured ectopic pregnancy with a blood clot, and so forth. It was not easy, however, to explain the positive Aschheim-Zondek test, since one would expect a negative report rather than a positive. But one could conceive of the possibility of there still being enough hormone action in the tissue to give a positive test.

We opened the patient's abdomen and found intestine and omentum densely adherent to a mass which filled the whole pelvis. The adhesions were carefully freed, finally exposing a cyst best described as being milky in appearance. We intended to remove this mass. Careful as was our dissection, the cyst wall ruptured, and a live fetus about the size of 4 to 5 months escaped from the mass. We knew then that there was nothing to do but to remove the entire mass. The fetus was baptized and the rest of the ovum removed. The placenta was attached to the lateral wall of the abdomen but was easily removed, without difficulty. This case resulted later in a discussion of the morality of the procedure with two theologians. There is no question that the removal of the mass, once the sac had ruptured, was morally lawful. However, if the abdominal pregnancy had been recognized before the sac ruptured and if the adhesions or other pathological changes were not threatening the life of the mother, the abdominal pregnancy should have been permitted to progress until a viable child could be delivered. We know of two cases of full-term

abdominal pregnancy which resulted in the birth of live babies. Neither of the obstetricians in these two cases knew he was dealing with an abdominal pregnancy until he opened the abdomen in preparation for doing a cesarean section.

**The Rh Factor.** The Rh factor will be understood better if we go back beyond the days of World War II and give the case history of a "mythical patient" who died either while receiving a transfusion or shortly after a transfusion had been given. The patient may have been admitted to the hospital because of loss of considerable blood owing to postpartum hemorrhage. Then, as now, the best treatment for that condition was transfusion. After the blood of the patient and of the donor had been typed, matched, cross-matched, and so forth, and it had been definitely decided that the blood of the donor was the same as the blood of the recipient-to-be, a transfusion would be given. The patient would improve to such an extent that it would be deemed advisable to give a second transfusion with the same good result; and a third would be given with more improvement. Now it was decided to give a fourth transfusion; and before one-quarter of the blood had run into the patient's vein, she showed signs of distress, — dyspnea (difficulty in breathing), a chill, and so forth. The needle would immediately be withdrawn from the vein with the thought that regardless of the very careful work done in the laboratory, this time (the fourth transfusion) there must have been some "slip-up" which demanded an immediate check-up. This check-up invariably showed that there was no mistake, that the patient was receiving

the type of blood that she should have received. Within a few days the patient had recovered from the effects of the fourth transfusion, and it was evident that she needed more fresh blood. A very careful examination showed that her heart and lungs and blood pressure were all normal; and that, although there had been evidence of some fresh blood in her urine immediately after the withdrawal of the needle in the fourth transfusion, her kidneys now seemed to be perfectly normal. It was then decided to give a fifth transfusion; and before this transfusion had ended, the patient had another collapse and this time she died.

The case is hypothetical only to point out something about the Rh factor, about which in those days we knew nothing. We know now, however, that that patient died because she was an Rh negative and had been receiving Rh-positive blood. Except for the presence of the Rh factor in the donor blood, the blood of both donor and recipient was exactly alike.

What is the Rh factor? It is a certain substance which about 85 per cent of the white race, called "Rh positives," have in their blood. The remaining 15 per cent do not have this substance and, not having it, are called "Rh negatives."

Landsteiner and Weiner, to whom the greatest credit must be given for the discovery of the Rh factor in the human, knew that this same factor was in the blood of all Rhesus monkeys and they called it the "Rh factor" from the first two letters of the word "Rhesus." In the Negro race 93 per cent are Rh positives and 7 per cent Rh negatives, and in the Chinese the figures are 99 per cent positive



and but 1 per cent negative. We are not ready to give any reason for the disparity of the factor in different races.

One must have at least a slight knowledge of antibodies before it is possible for him to understand the Rh factor problem. What are antibodies? When a patient becomes ill because of an infection — a disease caused by some bacteria — his blood assumes the task of curing him by manufacturing antibodies. We may truthfully call this process “Nature’s method for recovery.” The infected patient’s blood manufactures antibodies to fight the infectious material in the blood stream, now rampant there and caused by the attacking bacteria. When enough antibodies have been manufactured by the patient’s blood, the effects of the bacterial attacks are overcome and the patient gets well.

With the above facts in mind, we can now better discuss the Rh factor and state:

1. An Rh-positive female may marry an Rh-positive male, and there is no problem.
2. An Rh-negative female may marry an Rh-negative male, and there is no problem.
3. An Rh-positive female may marry an Rh-negative male, and there is no problem.
4. An Rh-negative female may marry an Rh-positive male, and there may be a problem.

Why this problem in situation No. 4, the marriage of the Rh-negative female and the Rh-positive male?

a. The baby to be conceived is to have the factor given it by the father’s spermatozoon, and it may be either an Rh-



negative or an Rh-positive embryo. If the embryo should be Rh negative, its blood would be identical with that of its mother.

b. If, however, the embryo should be an Rh positive, it could pass on, in the uterus, to the blood of its Rh-negative mother a certain something (the Rh positive factor) which its mother's blood does not contain, and the mother's blood might attempt to thwart this invasion or intrusion on the part of the fetus by manufacturing antibodies to fight off the attacker and, conceivably, could possibly kill the baby by breaking down the red corpuscles of the baby and bringing about a condition known as "erythroblastosis foetalis" (destruction of the fetal red blood cells).

If an Rh-negative female marries an Rh-positive male and if the Rh-negative wife had never had a transfusion with Rh-positive blood, it is a safe assumption that she might be able to give birth to four or five children without the Rh factor ever causing a problem.

As to the possibility of an Rh negative mother married to an Rh positive father losing a baby at or near full term, or of miscarrying in the early months, the salient facts are as follows:

1. If the Rh-negative mother has had a transfusion or transfusions with Rh-positive blood, there is more likelihood of her blood manufacturing antibodies as the result of an Rh-positive baby.

2. If she has not had a transfusion or transfusions of Rh-positive blood, there is little or no likelihood of trouble when she is pregnant for the first or second time.

3. If there is to be a problem and no transfusions have

been given, the obstetrician would expect the appearance of antibodies in the fourth or fifth pregnancy, rather than in the earlier ones.

4. The Rh-negative mother can have her blood examined periodically during any pregnancy to find out whether or not her blood shows antibodies. If there are no antibodies, there is no problem. If there are antibodies, one must be on his guard, and if in a pregnancy antibodies should appear and the baby has reached the stage of viability, the obstetrician should deliver the baby prematurely.

5. If antibodies appeared in a fifth pregnancy, one should suspect the probability of there being more antibodies in the sixth pregnancy and should advise the patient to follow the rhythm method.

6. The Rh-positive embryo can rarely do any harm to its Rh-negative mother unless there have been one or more previous transfusions of Rh-positive blood.

7. In so far as the obstetrical problem is concerned with the Rh factor, one must constantly think of the baby rather than the mother (if there have not been previous transfusions).

We would not go as far as do some obstetricians who today neglect to find out whether a new patient is an Rh negative or an Rh positive. But, on the other hand, neither would we be alarmed if we found out that the new patient was an Rh negative. It was not too long ago that a patient was referred to us from another state. The woman was pregnant for the third time and the pregnancy was about ten weeks. She was an Rh negative and the two previous

pregnancies terminated by miscarriage, each at about three months. She was told that the reason for her miscarriages was that she was an Rh negative. Her husband's blood had never been examined, but when it was, he too was found to be an Rh negative. It was plainly obvious, then, that the Rh factor had nothing to do with the two previous miscarriages. Some 6½ months later the mother gave birth to a perfectly normal baby.

In the early years of our knowledge of the Rh factor, there were those who were of the opinion that miscarriages on the part of Rh-negative mothers who had never given birth to a full-term baby could be explained by the Rh negative factor. Today this opinion is debatable, unless, of course, the patient had had previous transfusions of Rh-positive blood and antibodies are found in her blood at the time of the miscarriage.

## CHAPTER SIX

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### OTHER PERTINENT CONDITIONS

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#### HYDATIDIFORM MOLE

IN ANOTHER CHAPTER we have described the chorion and the amnion and have mentioned that these two tissues constitute the so-called "membranes." Each of them is subject to disease or abnormalcy and each, too, can cause complications which we feel should be discussed briefly in a book of this type.

An hydatidiform mole is the result of an abnormal proliferation with degeneration of the chorionic villi. Accompanying this proliferation and degeneration there is edema and the three result in the formation of small cystic bodies which cluster together to give the whole mass the appearance of large bunches of grapes.

It is our opinion that this condition has its inception in the very early days of pregnancy and progresses so rapidly that the fetus is quickly destroyed. We are not unmindful of the fact that some obstetricians and authors of textbooks are of the opinion that the condition may take place at any stage of pregnancy and that the combination of a live fetus or even a full-term live baby with an accompanying

hydatidiform mole is possible. All of them agree, however, that in most instances the fetus has perished and that visible or even microscopic evidence of a fetus cannot be found. We will agree that it is possible but rare to find in certain placentas — either of full term pregnancies or of miscarriages — small localized areas of cystic degeneration, and we will agree because we have seen such a condition. But we prefer to call this a cystic degeneration of the chorion, always localized; we do not classify it as a true hydatidiform mole. It is to be borne in mind, too, that when this localized condition exists its presence is discovered more or less accidentally after the expulsion of the fetus or baby and that the presence of these small localized areas has not caused any medical problem.

With a true hydatidiform mole there is a problem, not only a medical problem per se but also a very important moral one. Any discussion of the moral problem involved is based wholly and, we think, correctly on this: that a diagnosis of true hydatidiform mole connotes that there is no fetus either alive or dead concerned in the case.

To better understand the moral problem, it is well to first discuss the symptomatology of this condition. It is always a complication of the early months of pregnancy; to our minds it had its inception in the early days of pregnancy. The chorionic villi proliferate and degenerate so rapidly that at the date when the patient would consider herself two months pregnant the uterus may be of a size more commensurate with that of a four or five months pregnancy. This rapid increase in size is due to the proliferation of the cells plus the degeneration and edema.



The increase in size is so rapid that, whereas on the first day of any given month the uterus may be the size of a four months pregnancy, one week later it will be that of five months.

Invariably, all the normal physiological signs of an ordinary pregnancy are much more pronounced in the case of the hydatidiform mole. Nausea and vomiting are apt to be much more severe, and, very important, an Aschheim-Zondek test (the rabbit test) will be *much more positive* in this condition than in a normal pregnancy because of a greater secretion of hormones in the case with the chorion diseased. Likewise, this increase in the positiveness of the test is constant and can be readily detected from week to week.

In nearly every case there is apt to be a pinkish discharge due to the squeezing out of the small cysts of a fluid discolored by blood. Occasionally, some of the grapelike bodies are expelled from the vagina and when this happens the diagnosis is easily confirmed. Unfortunately, however, this does not happen in every case.

In a normal case of pregnancy, an x-ray examination at  $3\frac{1}{2}$  months will show evidence of skeletal structures; but with the hydatidiform mole and the uterus the size of a 5- or 6-months pregnancy, an x-ray will fail to show any skeletal structures. Of course, in the second instance we may know positively that the patient had conceived only two months previous even if the uterus is as large as a 5- or 6-months pregnancy. Nevertheless, the x-ray finding is helpful and important since it would prove that we have not made an incorrect diagnosis — that we were not deal-

ing with a case that was 5- or 6-months normally pregnant. We feel that it can be safely stated that if after  $3\frac{1}{2}$  months have elapsed since the date of conception, an x-ray examination fails to show any evidence of skeletal structures, it is because of the fact that there is none to show, nor was there ever any.

Once the diagnosis of true hydatidiform mole is positively arrived at, we consider it excellent judgment to remove the mole and feel that it is licit to do so since life has not existed since the early days of the pregnancy. When we see a case of hydatidiform mole, we always have another obstetrician see the patient with us and if he agrees in the diagnosis we then consult a clergyman, appraising him of all the facts and asking him to decide on the licitness of operating the patient.

### CHORIO-EPITHELIOMA

Chorio-Epithelioma is a malignant tumor which develops in the uterus as a result of the proliferation of retained chorionic tissue. These retained cells invade the uterine musculature and invariably cause metastases (extensions to other organs of the body). There are those who are of the opinion that a chorio-epithelioma may develop following a miscarriage or a full-term pregnancy but they state that it is far more apt to follow a hydatidiform mole. We have never seen a case that was preceded by either a miscarriage or a full-term pregnancy; in fact, in our lifetime we have seen but two cases, one which complicated a ruptured interstitial pregnancy which we saw as an interne

at the Boston City Hospital, and the other a case which we had in our private practice. Our one private case followed an hydatidiform mole and we consider it of sufficient interest to discuss it briefly.

The young lady became pregnant within six weeks of her marriage and consulted us because of nausea and vomiting which within a few days had to be classified a pathological *pernicious*. Her uterus at the time of her visit was much larger in size than it should have been for we knew definitely the date of conception. Although it was possible to relieve the nausea and vomiting to a considerable extent, those distressing symptoms never abated entirely. While hospitalized because of the vomiting, it was possible to note the uterus increase greatly in size from week to week. Finally, she showed marked evidence of a pinkish fluid discharge and one day she expelled grape-like bodies, the presence of which made the diagnosis of hydatidiform mole positive. After a conference with an eminent theologian who agreed that it was perfectly licit to empty the uterus of the mole, a digital and instrumental diletage was done, the curette being of the dull and not sharp type. At the time of this young lady's illness, there was no Aschheim-Zondek test nor had the specialty of x-rays advanced sufficiently to show either the presence or absence of skeletal structure. Necessary as is the conference with the clergyman today before emptying the uterus of its hydatid contents, it was far more necessary in those days when our knowledge of the subject was not what it is today.

The patient was discharged from the hospital about ten days following her operation and was closely followed at

her home. Within a few months she developed an irregularity of her periods, and her general physical condition could best be described as being below par. The possibility of her developing a chorio-epithelioma was constantly on our mind and when, one day, within four months of the time the hydatidiform mole had been removed she was suddenly seized with acute lower abdominal pain and showed signs of a beginning general peritonitis, we definitely made the diagnosis of chorio-epithelioma. Immediately, she was taken to the hospital and prepared for an emergency abdominal operation. We had at the hospital with us the late Dr. Frank Burr Mallory, one of the leading pathologists of his day. He was present in order to have an immediate microscopic examination made of the tissue, and to rule in or rule out the diagnosis of chorio-epithelioma.

The abdomen was opened and it distinctly revealed that the cause of her acute abdominal attack was the rupture of the uterus due to an invasion of its walls by chorio-epithelioma. Dr. Mallory quickly made the microscopic examination and gave the dreaded diagnosis. The tumor had already invaded not only the uterus but the omentum (the covering of the intestines) and also the appendix and meso-appendix. A complete hysterectomy with the removal of the entire uterus, the tubes, the ovaries, glands, omentum, appendix, etc. was done and during the operation the patient was constantly receiving fresh blood. This in an era when transfusion was not the easy operation that it is today. Regardless of the transfusion, the patient suddenly became pulseless making it necessary to pack the



pelvis with gauze drains and to do a quick closure of the abdominal incision.

We were told to give a prognosis of no more than two months if, by chance, the patient survived the immediate effects of the operation. Five days later we removed the drains, with the discharge of considerable pus — a peritonitis. Purulent material drained from her incision for some few weeks. She was finally removed to her home. About all that could be done for her was to give her “tonic treatment” since the day of radium and high voltage x-ray had not yet arrived. Two months had elapsed and her general condition appeared better and two more months elapsed with further improvement. Now nearly thirty years have elapsed and the patient is alive and well, enjoying life to the fullest extent and in the proper manner.

Many times I have asked myself, “Why did she live without any recourse to radium or deep x-ray therapy” — for of course they were not available in that day. I am of the opinion that it is one case of a general peritonitis that was helpful and not harmful, i.e. that the general peritonitis set up enough inflammation to have had any remnants of chorio-epithelioma that may have still remained in her abdomen slough away. But I have another opinion and it is this: both at the time of her operation and ever since then, the patient was a firm believer in the efficacy of prayer and I cannot but feel that her great faith and deep devotion had much to do with her recovery.

I have told the story of the patient's illness in order to impress on the mind of the reader that it must not be forgotten, when one sees a case of hydatidiform mole he must



always bear in mind the possibility of it being followed by a chorio-epithelioma and that he must be constantly on his guard for the appearance of symptoms. I have seen several cases of hydatidiform mole but only one that was followed by chorio-epithelioma. The possibility that chorio-epithelioma may follow in the wake of an hydatid mole should point up the importance of an early diagnosis and proper treatment of the hydatid.

### DISEASE OF THE AMNION

**Hydramnios.** In another chapter we have mentioned that the baby in utero is encased in the amniotic sac and is surrounded by a fluid known as the amniotic fluid. When there is more than the normal amount of fluid present, the condition is known as hydramnios. The increase in amount of fluid may be but slight and not cause any obstetrical problem, or can be very considerable and then possibly bring about a condition that we feel should be discussed briefly.

As to its cause, let it be said that no single definite factor can be used to describe its etiology. We do know that there is a proliferation of the cells of the amnion, thus bringing about a greater secretion of fluid and we know, too, that the condition invariably accompanies many abnormalities on the part of the fetus — to state a few, anencephalia, spina bifida, deformities of the extremities, etc. There is the possibility, too, that its presence may be influenced by disease on the part of the mother.

Whereas with hydatidiform mole the marked enlarge-

ment of the uterus occurs usually in the first trimester, the enlargement caused by hydramnios usually occurs in the last trimester. The outstanding sign is the increased enlargement of the uterus due to the presence in the amniotic sac of more than a normal amount of fluid. The increase may range from a few quarts to a few gallons. This marked increase in size can be a very distressing and, occasionally, a very serious complication. The rapidly enlarging uterus can cause sufficient pressure on the diaphragm to bring about a condition of dyspnoea (labored breathing) pronounced enough to make the patient really uncomfortable.

Fortunately, the condition rarely becomes a problem until the 8th or 9th month, at which time the baby is viable and the case can be treated easily and readily by either rupture of the membranes, thus allowing the escape of the greater part of the fluid, or by aspirating the sac with a needle, thereby allowing the drainage of the fluid to be a much slower process.

Very rarely, a case of troublesome hydramnios may be met with before the baby has reached the stage of viability and when this does happen, naturally it raises a moral problem but one quite easy to solve. Theologians are in agreement that it is perfectly licit to draw off fluid from the cavity of the uterus by means of inserting an aspirating needle through the abdominal wall and then into the cavity of the uterus, with the withdrawal of sufficient fluid to relieve the patient of her dyspnoea and distress. This can be done with there being but little, if any, likelihood of its causing a premature birth. If necessary, the procedure can be repeated until the baby has reached the stage of

viability, after which time, if deemed necessary for the benefit of mother or baby or both, the pregnancy can be terminated licitly by rupturing the membranes from below and allowing the patient to fall in labor.

**Hydrocephalus.** We will not discuss in detail or in academic fashion the etiology of the condition known as hydrocephalus. Suffice it to say that it is due to an abnormal collection of cerebro-spinal fluid which finally results in a marked increase of every diameter of the fetal head. The diameters of the head become so much larger than the diameters of the mother's pelvis that it is impossible to deliver the head through the natural passages.

In the early days of our practice, when we saw a case of hydrocephalus, (which, fortunately, was rare rather than often), we were confronted with a real problem as to the best method to handle the case. We recall one who had been in labor such a long time before being admitted to the hospital that it appeared not good judgment to deliver her by cesarean section. She was already running a high temperature because of an infection. We delivered her by an operation known as symphysiotomy, which means that we separated the bones of the pelvis by severing the cartilage which connects them anteriorly. By so doing we were able to enlarge every diameter of the pelvis sufficiently to allow the delivery of the hydrocephalic head through the bony pelvis. In other instances when we saw hydrocephalus, we would deliver the baby by cesarean section. If it were a problem to decide how to properly handle such a case previous to the year 1942, it is no longer a problem, thanks to the work done by Cornelius T. O'Connor, M.D.,

F.A.C.S. and Arthur J. Gorman, M.D. both of Boston, Mass. and both connected with St. Elizabeth's Hospital, Brighton, Mass., where their work was first performed. I will quote from a reprint of their article as published in the *American Journal of Obstetrics and Gynecology*:<sup>1</sup>

A 20 year old primigravida was admitted to the hospital. . . . A diagnosis of hydrocephalus was made and confirmed by x-ray. The patient was at term. She was anesthetized with nitrous oxide and oxygen and light ether. . . . The cervix was exposed with retractors. It was 3 cm. dilated. The child was baptized, using a long glass syringe. A No. 18 gauge spinal puncture needle was easily inserted into the presenting part. Cerebrospinal fluid immediately spurted under pressure. About 1400 cc. of fluid were removed. After the initial pressure was released, the rate of flow slowed somewhat. Abdominal pressure on the head resulted in a satisfactory return of the flow through the needle. About twenty-five minutes were spent in allowing the fluid to drain. Labor began almost immediately. X-rays were taken after the tap was finished. It was noted toward the end of the tap, that the head, now greatly collapsed and softened, was rapidly dilating the cervix and coming into the pelvis. Labor lasted one hour. The patient delivered normally. . . . The child was born alive and lived for two hours. . . . Autopsy of the child revealed marked atelectasis, internal hydrocephalus, spina bifida with meningocele, dorsolumbar atrophy of the spinal cord, and cerebellar adhesions to the dura mater.

I quote further from "Conclusions":

1. We believe that the simplest and safest method of treatment for hydrocephalus when it presents by the vertex is intraventricular tap and drainage per vaginam.

2. Intraventricular puncture abdominally as practiced by Wilson

<sup>1</sup>A.J.O.G. St. Louis, Vol. 43, No. 3, pages 521-524, March, 1942.



is recommended whenever introduction of a spinal needle through the cervix is difficult or inadvisable.

3. We believe that either of these procedures is superior to the recommendations in current texts, all of which require rather deep general anesthesia, more than a minimum of obstetric training and experience, and some of which are not without danger to the mother.

4. Intraventricular tap and drainage are permissible with Catholic patients.

We concur with the conclusions as stated by O'Connor and Gorman, and commend them for their work. Their method has given us an easy, safe and sane treatment for cases of hydrocephalus.

## ENDOMETRIOSIS

In the early years of our practice we would occasionally operate upon patients who showed definite pathology in the pelvis and whose principal complaint was lower abdominal pain, which was much worse at the time of menstruation. Some of these patients were single, others were married. Many of the married patients gave a history of sterility. At operation we would find a condition that was known then as "chocolate cysts of the ovary." If the ovary happened to be nothing but a shell, it would be removed. If there was still considerable healthy substance to the ovary, it would be resected, and all chocolate fluid would be wiped out from the pelvis. Some of these patients obtained relief by operation, and some would return six months later, complaining of the same symptoms for which operation was performed originally. What caused



the "chocolate cyst" we did not know. Why, after we had done what was considered appropriate surgery, many patients would still have the same symptoms, we could not explain.

In 1921, Sampson, of Albany, New York, reported that we were dealing with what he called "endometriosis." What is endometriosis? In order for the subject to be better understood, let it be said that the lining membrane which is thrown off from the uterus at each menstruation is the endometrium. Endometriosis is discussed in a book of this type because it happens many times that a gynecologist tells his patient that there is a possibility that the ovaries must be removed because of the condition, the operation resulting, of course in sterility. We want to point out that many times the ovaries will have to be removed and that the operation will be licit.

It is not our purpose to write a scientific treatise on endometriosis, but rather to discuss it in a manner understandable to our readers. Instead of discussing it from the usual standpoint of etiology (the cause of the condition), we will discuss its possible histogenesis (the origination and development of organic tissues). Where does this endometrial tissue, which is normally found only in the uterus, come from, and when does the doctor know that he is really dealing with a case of endometriosis?

We will answer the second part of the question first and say that one is dealing with a case of endometriosis whenever he finds endometrial tissue anywhere other than as the lining membrane of the uterine cavity. Sampson was of the opinion that the extension of endometrial tissue to other

parts of the female pelvis was due to transplantation of endometrium from the cavity of the uterus through the Fallopian tubes to the general peritoneal (abdominal) cavity. He postulated that because of a retroversion or a retroflexion (backward tipping of the womb), the uterine cavity at the time of menstruation could not drain itself adequately and that some of the menstrual blood and endometrial cells were "backwashed" through the tube into the abdominal cavity. He did not limit the possible causes of this backwash only to displacement of the uterus. He considered many other possible causes, mostly inflammatory or obstructive.

It cannot be denied that during the course of the simple dilatation and curettage of the uterus, especially in cases with a displacement, that endometrial cells may be forced through the Fallopian tubes into the cavity of the pelvis. Likewise, when radium is inserted for a just cause into the canal of the neck of the womb, with the muscle fibers of the cervix gripping the radium tube so tightly that any discharge from the uterus is prevented, it is possible that endometrial cells are forced back through the tube into the peritoneal cavity. It might be well to state that when a comparatively simple test like the Rubin test or the lipiodol test is done in an effort to find out whether or not the Fallopian tubes are patent (open), endometrial cells may be forced backwards through the tube. These tests (the Rubin and the lipiodol) are usually done, and correctly so, as part of the study of cases of sterility. In the Rubin test air is forced through the tube, and in the lipiodol test a liquid solution (iodine and oil) is likewise forced through the tube.

When endometrium is found in the middle or outer layers of the wall of the uterus, as it sometimes is (direct endometriosis), it can be looked upon as a direct invasion of the myometrium. This direct invasion of the myometrium by endometrial cells is many times accompanied by the formation of adenomyomata (fibroid tumors).

Possibly endometriosis may be explained by increased hormone action which may cause a metaplasia (a transformation of cells), which results in epithelial cells becoming cells more glandlike in character.

To our minds, not enough is known about the change of the simple epithelial cell to a glandular cell to have us discuss the matter academically. Meigs, of Boston, is of the opinion that endometriosis is seen more often in unmarried women or in married women who have not had children; and he concludes that the condition is caused by too great and too regular activity of the ovaries, this normal activity in some way causing an increase in hormone action ultimately resulting in metaplasia. He advocates early marriage and the rearing of a family during the first years of married life. He theorizes that the nine months' amenorrhea due to pregnancy and the added months of amenorrhea if the mother nurses her baby would lower the incidence of endometriosis.

Many years before Sampson's epochal work, endometrial cells had been found in the ovary. This discovery raised the question of the so-called "embryonic rest" theory, the thought being that the ovarian embryonic endometrial cells remained quiescent during infancy and childhood and that, when the age of puberty arrived, metaplasia of these

cells took place. It is our opinion that the implantation theory, that endometrial cells are forced through the Fallopian tubes into the abdominal cavity, explains many cases but positively does not explain all. Endometriosis of the lung has been reported; and in our own practice we have had one case of endometriosis of the female breast, the pathological diagnosis having been made by the late Dr. Frank Mallory and corroborated by the late Dr. Sampson. Certainly, endometriosis of the lung or the breast cannot be explained by direct transplantation and must be looked upon as cases carried to distant parts of the body by the blood stream or by lymphatics.

It might be well to state that there appears no doubt that sometimes, when one is operating on the uterus and has opened the cavity of the uterus, endometrial tissue can be innocently deposited either in the pelvis or in the abdominal wall. We have had one case of endometriosis with three recurrences in an abdominal incision.

We are not in agreement with those writers who say that they have seen evidence of endometriosis in 25 to 50 per cent of all cases operated by them for pelvic complaints, but we do feel that it occurs much too frequently to be looked upon as rare. Statistics would seem to prove that one is more apt to see endometriosis in women who are between the ages of 25 to 40, but it must be borne in mind that it can occur at any time from the age of puberty through the years until the cessation of the menopause. (A few cases of endometriosis have been reported in patients five to ten years after the cessation of menstruation at the time of the menopause.)



Whereas pain is a fairly frequent concomitant, it is nevertheless true that at operation endometriosis may be found in a patient who never suffered pain either premenstrually, menstrually, or postmenstrually. It is safe to say that pain will be present in the majority of cases. If the condition is an advanced one, there may be pain even during the intermenstrual cycle. Married women with endometriosis are very apt to be sterile; in fact, many times the diagnosis of endometriosis is made when a patient seeks the advice of the gynecologist as to treatment for her sterility. A pelvic examination may show enough to readily diagnose the condition, that is, there may be a mass on one or both sides, there may be a relative fixation of the uterus which cannot be explained in any other way, or one may feel small nodules in the pelvis through the posterior cul-de-sac.

It is our opinion that if one is suspicious of a case being endometriosis, the patient should be operated upon in order to find out how extensive the process is. At the time of operation, a decision must be made as to how to proceed. There may be an occasional case where it would suffice simply to break up adhesions and to remove endometriotic areas that can be easily and readily removed. We do not advocate removing small endometriotic bodies which may be found adherent to the rectum, the sigmoid, or other pelvic structures if to remove such small bodies may result in considerable hemorrhage and possibly accomplish but little good, if any, as far as the endometriosis is concerned. If, on the other hand, the condition is pronounced enough to warrant the removal of the endometriotic tissue, conservatism should be the watchword. If one



finds an ovary which is filled with chocolate-colored fluid and is nothing more than a shell, the ovary should be removed. If the process is bilateral instead of unilateral, and it is evident that the ovaries would prove to be a menace to the future health of the patient if not entirely removed, double oöphorectomy (removal of the ovaries) should be performed.

If it appears that we are dealing with a case of direct endometriosis in the wall of the uterus, especially if there are accompanying fibroids, the uterus should be removed; and it should be left to the judgment of the individual operator whether the hysterectomy (removal of the womb) should be complete or supravaginal. (Complete hysterectomy means the removal of the entire uterus, both cervix and body. Supravaginal hysterectomy implies leaving the cervix, the part of the womb in the vagina, *in situ*.) If a hysterectomy is done, the individual surgeon must make a decision in the individual case whether or not to remove the ovaries. Again, conservatism should be the watchword. If it is evident that only part of an ovary or of both ovaries is involved, it is far better to resect the ovary or ovaries (that is, remove the involved area and leave the part of the ovaries or ovaries that appear normal *in situ*). When this is done, in many cases there will never be a recurrence, but occasionally there may be. It is our opinion that it is better to be conservative and leave healthy-appearing ovarian tissue *in situ* even at the cost of a possible second operation, or treatment by deep x-ray. The x-ray treatment would result in a cessation of function on the part of the ovaries as permanent as would be accomplished by

complete oöphorectomy. We are opposed to the treatment of cases of endometriosis primarily by deep x-ray therapy and feel that such treatment should never be used until the abdomen has been opened and one is positive of his diagnosis.

It should be pointed out that there are those who advise the use of male hormones (testosterone), especially in cases of recurrence. However, we do not advocate this treatment, since we realize the many possible side effects that might follow; for example, the possibility of masculinization.

In conclusion, it should be stated that, whenever endometrium is situated or deposited anywhere except in the lining membrane of the womb, every such deposit may rightfully be looked upon, as far as bleeding is concerned, as a miniature uterus, the difficult complication being that, while the normal uterus provides a ready exit for the discharge of endometrium and menstrual blood through the cervix and the vagina, there is no exit for the discharge of blood or endometrium from the numerous endometriotic deposits situated either in the pelvis or in any other part of the body.

## CHAPTER SEVEN

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# REGULATION OF CONCEPTION

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### THE RHYTHM METHOD

**H**istory of the Method. The rhythm method will be better understood if we first discuss what we shall call the "Capellman theory." What is the Capellman theory? In the early days of our practice, before our knowledge of the rhythm method, occasionally a patient came to us, as occasionally one does now, telling us that although she did not want to break any of God's laws, supernatural or natural, conditions were such that she would like to lead a life during the next year or two that would not be sinful but that would make it possible for her to indulge in marital relations without becoming pregnant. We thought in those early days that we had a ready, easy, honest answer. We would very carefully instruct the patient to refrain from relations for one week or ten days after the cessation of a period and for one week or ten days before the onset of her next period. We told the patient that it was perfectly safe for her to limit her relations to the time midway between her period. Our results were rather confusing. Of ten patients given such instructions, three might report

within a year that pregnancy had not occurred, but seven would report to us with an entirely opposite story. It is not our idea to ridicule Father Capellman or Father Capellman's theory. We simply wish to point out that so little did the physicians of that era know about ovulation and menstruation that Father Capellman, governed wholly by the obstetrical and laboratory opinion of the day, believed that we the supposed authorities must be right.

We know today that in advising patients to follow the Capellman theory, we were having them refrain from intercourse at the two periods during the menstrual cycle when they could not become pregnant and indulge in marital intercourse at the only time when it was possible for conception to take place.

What is the "rhythm" method? The medical world was astonished about twenty-one years ago by the announcement of two independent workers that they had found out conclusively that ovulation occurs but once a month and that it always occurs about twelve to fourteen days previous to what would be the first day of the next menstrual period if pregnancy did not ensue. One was a Japanese, Ogino, and the other an Austrian, Knaus. Neither one knew that the other was working on the same problem, nor did either know the conclusions of the other until both published their results almost simultaneously.

One of the authors wishes to state his feelings about the matter when Knaus and Ogino published their results. He was asked by an eminent Jesuit to review articles written by both. He consented to do so and reported his opinion at great length. It will be readily understood that the re-

marks made about the Capellman theory in a previous paragraph were not made in ridicule, because at that time the reviewer backed up Father Capellman and completely disagreed with both Ogino and Knaus. He made up his mind, however, to examine the ovaries of every patient upon whom he operated after that date. Six months later he notified the Jesuit that although his series of cases was not in the thousands, it was, nevertheless, large enough for him to conclude that Knaus and Ogino were probably correct in their opinion; and within a year he knew for a certainty that they were correct and that he and most obstetricians were entirely wrong in their previously held opinion.

Even before the days of Knaus and Ogino we knew that there was a certain relationship between menstruation and ovulation, many thinking that they were synchronous. There were some who thought that one preceded the other by a few days to a week, but which one preceded the other was not known. Today we know for a certainty that the female with a 28-day menstrual cycle ovulates 12 to 14 days before the first day of her next expected period. We know positively, too, that if the ovum extruded at ovulation is impregnated, there will be no period 12 to 14 days later and that if the ovum is not impregnated, menstruation will follow on the date expected. We know positively, too, that if the ovum expelled in the middle of one menstrual cycle is not impregnated, it is absolutely impossible for the patient to conceive until she extrudes another ovum midway between menstrual dates — that is, about 28 days after the preceding ovulation.

In other chapters we have discussed the relation of hor-



mones to both menstruation and ovulation. Consequently, we will not discuss it here but will confine our remarks wholly to the rhythm method as a *natural* method of birth control.

There is still no unanimity of opinion as to the length of time during which it is possible for the extruded ovum to be impregnated by the spermatozoon, nor is there unanimity as to how long the spermatozoon retains its power of impregnation. We are of the opinion that each may possess it for a period of from six to thirty-six hours. We consider it good judgment, however, when explaining the rhythm method to a patient, to extend the time of possible vitality to three days.

Is it morally right and proper for a patient, because of purposes of health or because of serious economic reasons, to limit her marital relations to the time when it is impossible for conception to take place and to avoid having relations at the time when conception possibly or probably or certainly could take place? Our answer is "Yes!" and it is based on a pronouncement of Pope Pius XI made on December 31, 1930, when he issued an Encyclical declaring:

Nor must married people be considered to act against the order of nature, if they make use of their rights according to sound and natural reason, even though no new life can thence arise on account of *circumstances of time* or the existence of some defect. For there exist also, both in marriage itself and in the conjugal use of the rights which it confers, some secondary ends, for instance, mutual assistance, the fostering of mutual love, and the allaying of concupiscence; and these aims the parties are not in the least forbidden

to pursue, always under the condition, however, that their action preserves its intrinsic nature and therefore also its necessary relation to the primary end. (*Italics ours.*) <sup>1</sup>

Although the Pope's pronouncement is very clear, we nevertheless feel that it is better for the clergyman either in or out of the confessional to be the one to pass judgment on the propriety of its use in each individual case. It has been our custom to suggest to every patient that she first talk the matter over with her confessor or clergyman and then report his opinion to us.

We constantly remind those patients who seek information about the rhythm method for other than medical reasons of an organic nature that they should not follow the rhythm theory for the rest of their lives. Conversely, the opinion expressed to the woman with rheumatic heart disease or a chronic interstitial nephritis or with diabetes or tuberculosis, to mention a few conditions, is that she should follow the rhythm method indefinitely, even for the rest of her married life if her medical condition does not improve.

MMMMSSSSSS S S F F F F F F F F S S S S S S S S M  
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

**How to Reckon Ovulation.** If a patient has a menstrual cycle of 28 days and she flows for four days, a chart giving her the necessary information can easily be drafted. For example, if a patient's last menstrual period started on January 1, she should expect her next period on January 29. She flows for four days. We put above January 1, 2, 3,

<sup>1</sup> Rev. John A. O'Brien, Ph.D., *Legitimate Birth Control*.

and 4 the letter *M* for menstruation. We put above January 29 another *M*, which is to be the first day of her next period. We put above January 15, 16, and 17, three large *F*'s for fertile. Over January 14 and 18 we put smaller *F*'s than those over 15, 16, and 17, indicating that there is a possibility of pregnancy ensuing if there are relations on those dates. We put a still smaller *F* over January 13 and 19, signifying a lesser possibility of pregnancy taking place on those days than on the fourteenth and the eighteenth, and we put a very small *F* over January 12 and 20 indicating that there is the least possibility of pregnancy taking place on the twelfth and the twentieth. Over the other dates we put an *S* for sterile and point out that there is no likelihood of pregnancy ensuing from marital relations on those dates. For those with irregular periods we stress the fact that the closer the date of intercourse is to the end of the preceding period or to the start of the next period, the greater is the safety.

We have instructed hundreds of patients successfully in the rhythm method. If a patient has her periods regularly every 30 days, the three large *F*'s are to be moved forward toward the first day of the next period, but we would advise that the large *F*'s for the 28-day cycle remain; that is, we would have five large *F*'s instead of three. If the patient has a 25-day cycle, we would move the three large *F*'s three days back toward the last day of the last period, but we would also allow the large *F*'s for the 28-day cycle to remain.

If a patient has irregular periods, for example, first a 28-day interval, next a 33, next a 31, next a 29, next a 26, and

so forth, we leave the large *F* over the dates corresponding with the earliest possible start and the latest possible start, that is, from 26 to 33 days.

Obviously, it is not easy to figure the time of ovulation for the patient who may have periods anywhere from 28 days to 34 days apart or longer. However, this type of patient can be treated with proper hormones in an effort to have her menstruate more often and more regularly; and when this improvement takes place, as it does in many cases, it is easier to instruct her properly. Until such improvement takes place, about all one can conscientiously do is to advise the patient to restrict her relations to the first few days after each period and to have no relations until there has been another period, since it is difficult to determine her ovulation time accurately.

There are some who believe that the time of ovulation can be determined by the recording of the body temperature rectally and daily, and they are of the opinion that at the time of ovulation there is an increase in body temperature of from  $0.2^{\circ}$  to  $0.5^{\circ}$ .

There is no unanimity of opinion to the effect that a temperature change occurs, and we have serious doubts as to the efficacy of dating the time of ovulation by body temperature, either rectal or oral. Since, however, it is our desire to have a book of this nature informative, we feel duty-bound to mention that there are those who do not agree with our opinion.

We are firm believers in the safeness of the rhythm method. We have compared our figures with those given out at certain so-called "birth control clinics" where con-

traceptives, and so forth, are the vogue. Our statistics are always better than are those from the contraceptive clinics.

In the first half of our gynecological and obstetrical career, much of our abdominal surgery was for the purpose of possibly correcting causes of sterility. Now, with the knowledge given us by Ogino and Knaus, we operate but rarely for sterility and then only for those cases where a lipiodal test or a Rubin test shows the cause of the sterility to be mechanical — principally closed fimbriated ends of tubes resulting from an old pelvic inflammation. Today, owing to the universal use of the sulfa drugs, penicillin, streptomycin, aureomycin, blood transfusions, and other discoveries, we no longer see the pelvic inflammatory cases we often did years ago. We can truthfully say that in recent years many cases referred to us because of sterility have become pregnant as a result of the patient following the rhythm method. Thanks to the work of Ogino and Knaus and thanks, too, to the pronouncement of Pope Pius XI, the rhythm method gives us a safe and accurate way to handle our problems which is not contrary to God's law.

## METHODS FOR PROMOTION OF CONCEPTION

**Treatment of Infertility.** In the rational handling of cases in which a married couple fail to have children in spite of their normal relations and even in spite of following the rhythm method and utilizing the fertile period, an investigation of the fertility of either or both parties, with treatment if indicated, is in order. (Here we omit discussion of cases of impotence, either absolute or relative.)



This subject has received widespread attention, and many fertility clinics have appeared within our time.

The causes of infertility are numerous: for instance, absence or defects of the spermatozoa, obstruction to the paths of spermatozoa or ova because of infections and resulting scars in the male *vas deferens* or other organs, or in the Fallopian tubes, temporary or permanent lack of ovulation and so on.

If there is no mechanical obstruction to the discharge of sperm, the usual procedure is to examine the semen to determine its quality and quantity, the number of spermatozoa present, and their condition in regard to size, shape, and motility. One must never obtain a specimen of semen in a manner which is clearly and plainly contrary to moral law. We regret to state that many times the specimen is obtained as a result of wilful masturbation or by the equally immoral use of a condom (male contraceptive) at the time of coitus. We cannot use words too strong in our condemnation of these two methods. Another method of obtaining semen for a laboratory examination is by the Huhner technique, which consists of aspirating from the vagina, after normal relations have taken place, a small amount of semen for examination. We feel that the Huhner method is permissible for the serious reason of examination with the view of promoting pregnancy.

The constitutional approach to the treatment of male infertility is so well described in a letter from Dr. Abner I. Weisman<sup>2</sup> of New York that we quote it here and adopt his opinion as our own:

<sup>2</sup> *J. Am. Med. Assoc.*, July 5, 1947, p. 914.

In supervising the "husband regimen" of hundreds of males and personally analyzing their semen specimens, I am happy to state that there is improvement in spermatozoal output in practically every instance if the patient abides conscientiously by his physician's advice. In treating the male as a constitutional individual rather than as a man who simply possesses testes, most incredible results are obtained. Every effort should be made first to ascertain any underlying physical defect. Similarly, the physician should delve into the patient's psychological make-up. His general health, his overwork, his lack of rest or sleep, his nervous exhaustion, his improper diet, his mode of life, his occupation, his frequency of sexual relationship — all should be gone into.

A "husband regimen" devised along the lines of improving that particular individual should be worked out. He should be advised concerning his diet — the type of food, the method of cooking his food, the vitamine and mineral-containing foods, and so on. He should be informed about the need for a well regulated mode of living — hours of sleep, proper amount of rest and relaxation, avoidance of excessive physical or emotional strains. He should be told of the deleterious effect of excessive coitus, of excessive uses of alcohol, of overindulgences in general. In essence, the patient who desires to increase his chances of impregnation should be told to care for himself in much the same way as an experienced animal husbandryman cares for a prize bull or sire. There is no question of doubt that in all the laws of breeding the individual who is the most normal and healthy will be able to produce the very best sperm that he, as an individual, can manufacture.

The administration of testosterone propionate or other form of male sex hormone and the use of thyroid may also help in overcoming the existing infertility.

These methods of treatment are perfectly lawful from the moral viewpoint, as are also the surgical corrections of physical defects in both parties.

**Artificial Insemination.** This method of promoting pregnancy is one by which union of the ovum and spermatozoon is brought about in some manner other than the depositing of sperm in the vagina by sexual congress followed by the natural migration of spermatozoa through the uterus and tubes. Its use in the human represents an application to the human of methods used in the cultivation of plants, the breeding of cattle, sheep, and other animals, in husbandry, and the study of genetics in the experimental laboratory.

The procedure consists of the injection into the uterus of spermatozoa obtained from the husband or another man called a "donor." The method by which the sperm is obtained and the person from whom it is obtained determine the licitness or illicitness of the act.

The first method to be considered consists of the collection of the semen which has been deposited in the wife's vagina during normal intercourse with her husband, and its injection into the uterine cavity by means of a syringe. It may be injected immediately after intercourse, or it may first be centrifuged to bring about a greater concentration of spermatozoa in a given volume of semen. The method of collecting the semen may vary, provided it has been deposited naturally in the vagina. This method is morally justifiable when there is sufficient reason for its use to facilitate pregnancy. In fact, it is not, strictly speaking, artificial, but is rather an aid to natural insemination. In reference to this method, Pope Pius XII, in condemning artificial insemination, says:

With such a pronouncement one does not necessarily proscribe

the use of certain artificial methods intended simply either to facilitate the natural act or to enable the natural act, effected in a normal manner, to attain its end.

Another method is the collection of semen from the epididymus or seminal vesicles of the male by syringe and needle. Since this is neither preceded by a natural act nor intended to "enable the natural act, effected in a normal manner, to attain its ends," it comes under the heading of methods proscribed by Pius XII.

Another method of collecting semen is by the use of a condom by the male, either during intercourse or during masturbation. Since voluntary masturbation is a mortal sin and it is impossible to conceive of it being involuntary under the circumstances, this method is unlawful. The use of condoms during intercourse in married life has been repeatedly and universally condemned by moral theologians in their treatises on contraception. The question is frequently raised as to whether the condemnation applies when the condom is used in the effort to promote pregnancy rather than to prevent it. However, the use of a male condom prevents natural intercourse, since it obstructs the deposition of semen into the vagina, which is an essential element of true marital congress. It is argued that the use of condoms is necessary in the study of the husband's fertility, to determine the quantity of semen and consequently the number of spermatozoa present in an ejaculation. This argument is based on the assumption that a full quota of spermatozoa is necessary, but Tyler and Paine report:

In a few cases we have utilized for artificial insemination speci-

mens of the husband's semen which were about 50% below average and have obtained pregnancies.<sup>3</sup>

The use of a perforated condom to collect part of the semen while a small part of it is allowed to enter the vagina to satisfy the technicality of the law not only interferes with the natural act, but defeats the purpose of measuring the quantity of the ejaculation and offers no advantage over the collection of semen from the vagina following intercourse.

A particularly vicious and not too uncommon method of obtaining semen for artificial insemination is the use of donor seminal fluid. This is semen obtained from a man who is not the husband of the woman to be impregnated. It is obtained by the use of a condom during masturbation or intercourse; and it is advised that the donor be carefully checked as to health, fertility, and so on, and that he resemble the husband as much as possible in physical and other characteristics. Judging from the reports in professional literature and at present unpublishable reports from other sources, not only is the use of donors prevalent, but professional donors have been solicited in the same fashion that paid blood donors are.

The use of donor seminal fluid introduces matters legal as well as moral. The Supreme Court of Ontario, Canada, "upheld charges of adultery against a wife who was alleged to have attempted to have a 'test-tube' baby in this language: 'The essence of the offense of adultery consists not in the moral turpitude of the act of sexual intercourse but in the voluntary surrender to another person of the repro-

<sup>3</sup> *J. Am. Med. Assoc.*, June 28, 1947.



ductive powers or faculties of the guilty person.' (Oxford *vs.* Oxford: Ontario Law Reports 49:15)." <sup>4</sup>

The French law also recognizes the use of donor seminal fluid as adultery, and in the case in which it is accomplished without consent of the wife, looks upon it as rape.<sup>5</sup>

It requires little consideration to realize the potentialities of future marital discord on the part of the spouses concerned and of delinquency and other mental, moral, and emotional disorders on the part of the child from this practice.

Pope Pius XII has the following to say in a statement to the Fourth International Convention of Catholic Physicians, October, 1949:

We have already had many occasions to speak on a good number of special points regarding medical morality, but now we have here a question of the first order, which with no less urgency than other questions requires the light of Catholic doctrine: it is the question of artificial insemination.

We could not allow this opportunity to pass without indicating briefly a general outline of the moral judgment regarding this subject.

1. The practice of artificial insemination, when it is applied to man, cannot be considered exclusively, nor even principally, from a biological and medical viewpoint, while leaving aside the viewpoint of morality and law.

2. Artificial insemination outside marriage is to be condemned purely and simply as immoral. In fact, the natural law and positive Divine Law are such that the procreation of a new life may

<sup>4</sup> Hamblen, *Endocrinology of Woman* (Springfield, Illinois: Charles C. Thomas, 1945), pp. 522 and 523.

<sup>5</sup> Letter of Paris correspondent in *J. Am. Med. Assoc.*, November 15, 1947, p. 729.

only be the fruit of marriage. Marriage alone safeguards the dignity of husband and wife — and in the present case, particularly that of the wife — and their personal well-being. Marriage alone provides for the good and for the education of the child.

Consequently, there is no possibility of any divergence of opinion among Catholics regarding the condemnation of artificial insemination outside marriage. A child conceived in such conditions is, by this fact alone, illegitimate.

3. Artificial insemination in marriage, with the use of an active element from a third person, is equally immoral and as such to be rejected summarily. Only marriage partners have mutual rights over their bodies for the procreation of a new life, and these rights are exclusive, non-transferable and inalienable. So it must be out of consideration for the child.

By virtue of this same bond, nature imposes on whoever gives life to a small creature the task of its preservation and education. Between marriage partners, however, and a child that is the fruit of the active element furnished by a third person — even though the husband consents — there is no bond of origin, no moral or juridical bond of conjugal procreation.

With regard to the lawfulness of artificial insemination in marriage, it is sufficient for us at present to recall the principles of the natural law: the simple fact that the desired result as obtained by this means does not justify the employment of that method itself; nor yet does the desire of marriage partners — most legitimate in itself — to have a child, suffice to prove the lawfulness of a recourse to artificial insemination for the fulfillment of that desire.

It would be false to believe that the possibility of a recourse to that method would render a marriage valid between two persons who are unfitted to contract marriage because of the impediment of impotency. Moreover, it is superfluous to indicate that the active element can never be lawfully obtained by acts that are contrary to nature.

Although one may not exclude *a priori* the use of new methods

simply on the grounds that they are new, nevertheless, with regard to artificial insemination, it is not only a case of being extremely reserved, but it must be rejected entirely. With such a pronouncement one does not necessarily proscribe the use of certain artificial methods intended simply either to facilitate the natural act or to enable the natural act, effected in a normal manner, to attain its end.

The medical doctor would not be corresponding fully to the ideal of his vocation if — while profiting from the most recent advances of the medical science and art — he used in his quality of practitioner merely his intelligence and ability; if he did not also make use (and we were about to say, above all) of his heart as a man, and of his loving tenderness as a Christian. . . .

Undoubtedly, the doctor's ministrations are to bodies, but to bodies animated with immortal and spiritual souls. By virtue of a mysterious but insoluble bond between the physical and the moral, he only acts efficaciously on the body when, at the same time, he is acting on the spirit.

Whether he be dealing with the body of the human being in its entirety, the Christian doctor will always have to beware of the fascination of science and the temptation to use his knowledge and his art for ends other than the care of the patients entrusted to him. . . . ”

In the meantime, methods have been developed of collecting ova from female animals by washing them from the surface of ovaries exposed by surgical operation. The ova are then fertilized by placing them in contact with spermatozoa obtained from the male and then introduced into the uterus or tube of the same female or another one. It is even possible to obtain embryos without spermatozoa among some of the lower animals by mechanical stimulation of the ova. The application of such methods to

humans has not yet been reported as far as we know, but is predicted by some of the active artificial insemination experts.

## METHODS FOR PREVENTION OF CONCEPTION

**Introduction.** It is safe to say that the newly married Catholic couple know that direct abortion, therapeutic or criminal, are sinful and consequently can never be considered as proper in any case. Many such young couples, however, are not cognizant of the fact that it is sinful for the wife to take a douche immediately after intercourse when the douche is taken for no other reason than to prevent the possibility of pregnancy.

**Douches.** It has been our experience that it is quite easy to convince those who inquire about the right or wrong of taking douches immediately after relations, with the intent to avoid possible pregnancy, that it is sinful to so do. There is doubt in our minds as to whether pregnancy could be prevented by the taking of a douche soon after relations. Since the intent of the one taking the douche is, however, to prevent pregnancy, there is no question that certainly the act is sinful. It is well to mention here that in each ejaculation on the part of a male some three hundred million-plus spermatozoa are inserted in the vagina and that it takes but one single spermatozoon to fertilize the ovum. The chemistry of the cervical canal with its mucous plug being as it is, it is doubtful if a douche taken only a few minutes after relations could wash out of the genital tract all spermatozoa ejaculated there.

We wish to state that theologians are in agreement that it is perfectly licit for a female who has been raped to take a douche as soon after the assault as it is possible for her to do so. Theologians have good grounds for this opinion, since the female involved is in no way a willing party to the assault. There is unjust and wrongful and sinful aggression on the part of the attacker. But even in a case of rape, where it is licit for the douche to be taken, we doubt that it possesses much, if any, efficacy in preventing pregnancy. Let it be understood that whereas theologians are in agreement that it is licit to take a douche shortly after the assault, theologians are just as strong in their agreement that nothing else can be done morally; for example, induction by abortion, criminal or therapeutic, would be murder. We are in agreement with those theologians who consider it licit to take a douche in a case of rape, if taken within minutes of the time of occurrence of the assault; but, it is hard to conceive how it would be possible under the circumstances for the douche to be given within such a short time.

We have been asked many times as to the licitness of a patient taking a douche after intercourse for what the patient calls "purposes of cleanliness." We realize how fastidious many women can be, but we find it difficult to understand why one should insist on taking a douche for cleanliness when the marital act is a perfectly natural act. We advocate bringing about "cleanliness" by the patient taking a tub or shower bath at a time convenient to her but not too close to the time of the performance of the act.

On one occasion one of us was suspicious that the story



of rape told by a young lady was not truthful. Our "lead" was due solely to the fact that the young lady had immediately "taken a douche," so she said, after the assault, and she informed us that she knew that her act was licit. Her situation in life was such that it was difficult to understand why she should know so much moral philosophy that she should have at her fingertips the licitness of a douche quickly taken. Time proved that she was not raped and that there never was an assault.

**Abstinence from Intercourse.** With our knowledge of the rhythm method and its licitness, it will not be necessary to devote too much space to the question of abstinence. A generation ago, when our knowledge was less than it is today, we were often asked as to the lawfulness of preventing pregnancy by abstention from the marital act. Our answer was that there was nothing wrong in abstaining if both husband and wife were agreeable to abstinence; but that if one was agreeable and the other was not, the reasonable wishes and viewpoints of the one not in favor of abstinence would have to be considered. That consideration would lead us to the conclusion that abstinence was lawful only when both husband and wife were in agreement.

Today, when for sufficient reason it has been deemed proper after consultation with a clergyman for a patient to follow the rhythm method, the question of complete abstinence rarely arises. It should be very easy for any husband and wife of any age to abstain from relations for the comparatively few days necessary to abstain, if the rhythm method is to be adopted.

**Coitus Interruptus.** It has been our experience that the problem of so-called "coitus interruptus" is not met as often as it was before our knowledge of the rhythm method. Nevertheless, regardless of this change, it is probably the most frequent form of contraception. Coitus interruptus or Onanism or "the spilling of the seed" consists of the male withdrawing just prior to his orgasm with the resultant "spilling of the seed" outside the introitus of the female. It is sinful and also harmful: sinful because it is contrary to nature and is done to prevent the possibility of conception, harmful because it is unnatural for the male, owing to the withdrawal at the height of the orgasm with the resultant changes in the organ after withdrawal. It is sinful for the female because of her implied willingness to perform the act in that manner, and it is harmful because of her being unable in most instances to reach an orgasm.

We are of the opinion that coitus interruptus, if indulged in to any great extent, can possibly result finally in sterility for either one or both of the married partners. It is difficult to produce figures to prove such a statement, but we have seen cases of couples who, after practicing Onanism for a long period, then wanted to bring forth children and were unable to do so. Certainly, as stated above, the changes that take place in the organ of each may bring about serious results. We can state positively that the prolonged practice of Onanism can cause serious mental upsets because of the fact that one or both of the parties involved finally realizes the wrongfulness of the act and develops a decided neurotic complex.

It may be stated that the rhythm method has accomplished much for married couples, not the least of which has been the lessening of sinful temptations in so far as the marital act is concerned. The priest hears enough, however, about Onanism to warrant mention. This is particularly true because many married people who "withdraw" appear to be in error about the "purpose of amendment" necessary for valid absolution in the Sacrament of Penance. In this case it is not enough to promise to try to avoid committing the sin. It is easier to avoid committing the sin than to commit it, since it is easier to complete the marital intercourse than to interrupt it. The resolution to restrict intercourse to the sterile period, with the implied reservation that it will be interrupted if it occurs during the fertile period, can hardly be interpreted as true contrition necessary for worthy Confession. Penitents in this case should determine that any subsequent marital intercourse will be completed. If pregnancy threatens to be a danger to health or life, which it seldom is, then the spouses, if they must have intercourse, are faced with the same choice as the martyrs — God's grace or temporal welfare without His grace.

**Castration and Sterilization.** The term "castration" implies the removal of the gonads: the testes in the male and the ovaries in the female. One can readily understand that the patient becomes sterile if these organs are removed.

Sterilization can be brought about by castration; but there are many other ways that a patient, male or female, can be made sterile without the removal of the gonads. In the male the small tubules that carry the semen from the

testicle to the urethra can be removed or tied off, so that it is impossible for semen to be ejaculated. In the female the Fallopian tube, through which the spermatozoon travels to meet the ovum in the abdominal cavity, can be either severed or crushed to destroy the continuity of the passage, so that conception is made impossible.

It is licit to remove the gonads for proper surgical indications, such as, in the male, a malignant growth of the testes or inflammatory conditions resulting from trauma to the testes. In the female it is licit to remove the ovaries if there are proper surgical indications such as tumors or cysts of the ovaries, to remove the Fallopian tubes if they are diseased, and to remove the uterus for tumors, benign or malignant, etc. But when the gonads are operated upon for any indication other than a legitimate surgical one, the operation is rightfully classified as an unjust mutilation; and a mutilation done solely for the purpose of making a patient sterile is sinful.

There are other ways to bring about sterility in either sex, principally radium or x-rays. And let us stress the fact that sterility by means of radium and x-ray can be made just as permanent as it can by surgery. If it is plainly evident that the organs necessary for procreation in each sex are diseased and the disease or condition is such that operative means should be taken for preservation of the patient's health, the operation is perfectly licit even if it results in sterility. On the other hand, if an operation is done on these organs for no other reason than to make it impossible for procreation to take place, it is contrary to Nature and is most sinful.



Let us state here that it is sometimes licit to bring about either a temporary or a permanent sterility when the organs are of themselves perfectly normal. For example, it is deemed good judgment in certain cases of cancer for the surgeon to recommend that the ovaries or testes be made to lose their function as part of a treatment given for a condition not primarily related to those organs. The male suffering from a malignancy of his prostate can be treated by x-ray therapy or radium even if removal of the prostate gland has already taken place and the x-ray treatment might cause changes in the testes which would result in sterility. And the female suffering from cancer of the breast could be given deep x-ray treatment of her ovaries which would bring about a cessation of function in them and reduce to a minimum the possibility of a further spread of the cancer of the breast to other parts. In the case of the male prostate and testes, the sterility results because of the close proximity of one organ to the other. In the case of the female, the x-ray treatment is given to the ovaries because of the hormone link existing between the breast and the ovaries. All theologians agree that treatment for such conditions is licit.

It seems safe to state that the female is more often sterilized, both licitly and illicitly, than is the male. We regret to state that there are those obstetricians who arbitrarily rule that if a patient has been delivered as many as three times by cesarian section, she should be sterilized in order to prevent her from having a fourth or fifth cesarean section. The obstetrician accomplishes the sterilization when he does the cesarean section by severing the tubes and burying



the distal ends in the folds of the broad ligament, thereby destroying the natural path for the spermatozoon and impregnated ovum through the Fallopian tube. One of us has been asked twice to attempt to correct this condition surgically. In each case an attempt was made by performing an operation that theoretically appeared perfect but, nevertheless, was not successful. One cannot interfere with Nature's organs to the point of destroying their function and then hope to have that function restored.

Such an opinion that it is dangerous for a woman to undergo more than three cesarean sections is not only most arbitrary but also false. One of us has performed eight cesarean sections on one patient, seven on another, six on a few, and four or five on several. As many as eleven cesarean sections have been performed on the same patient.

**Therapeutic Abortion.** Therapeutic abortion may be described as an abortion which is performed supposedly in the interest of the patient's health and is supposedly, too, free of all criminal intent. In years gone by therapeutic abortions have been recommended and have been done for sundry reasons, for example, on women who are pregnant and are suffering from hyperemesis gravidarum or from a real or functional or supposed heart condition, or from nephritis, diabetes, or some other disease. The therapeutic abortion is supposedly done to conserve the patient's health, the supposition being that if the patient were to go to term, the condition would become aggravated and her health would suffer.

A few years ago Cosgrove, of the Margaret Hague Hospital in Jersey City, New Jersey, wrote an article on the

incidence of therapeutic abortions. The number of therapeutic abortions ranged from 1 in every 35 admissions in one hospital to 1 in 16,500 admissions at the Margaret Hague Hospital. Cosgrove's figure was 4 therapeutic abortions in 66,000 admissions. We are proud of Cosgrove, since his figures show how conservative he is in the handling of such cases; and we rate him very highly in the field of medicine. It is not our idea to detract one iota from the great record established at the Margaret Hague Hospital; but we are glad to relate that since March 1, 1923, we have had many more than 66,000 admitted to our Service, and not one therapeutic abortion has been performed. We are glad to state, too, that our mortality from those conditions supposedly benefited by therapeutic abortion has been zero.

In speaking of our results at our home hospital, we are reminded of one very interesting case. At the conclusion of a lecture one of us was approached by a student who sought information concerning a member of his family. The history was as follows: The young lady had had a hysterotomy (opening of the uterus and removal of a three-month fetus) and then had both tubes tied or buried because of her having a heart condition. The operation had been done a year or two before, but now the patient had gone three months without a period even though she had been told that because of her sterilization she would never become pregnant again. Examination revealed that she was three months pregnant. She did have a heart condition, but with proper care she was carried to the start of the ninth month and was then delivered of a living baby by

cesarean section. This happened some years ago, and the patient is still alive. This case proves that no matter how expert a technician a particular surgeon may be, he is not so good as to be always able to defy Nature's laws.

It is sad to relate that in some sections of our own country certain individuals with criminal records are being sterilized because some psychiatrists and penologists are of the opinion that that is the best way to treat them. Whether the sterilization is to be brought about by castration or by operating on the sex organs so that it will be impossible for the individual to procreate in the future, we are rightfully opposed to it and insist that this is interfering with cases that should be governed by supernatural and natural law and not settled in a courtroom. Invariably, the type of operation done is such that the patient, male or female, is bereft of the power to procreate; but the operation has no effect upon the ability of the male or female, so "punished," to indulge in sexual congress. Does it cure a criminal, male or female, to operate in a way that prevents the power of procreation but at the same time allows the individual to lead a sexual life as bad as his life before the operation and often worse? The answer is "*No!*" We are not unmindful of the fact that the males and females so treated gave permission to the proper authorities to have such operations performed.

**Mechanical and Chemical Devices.** The market today is flooded with mechanical and chemical devices designed to prevent conception with a minimum of interference with sexual pleasure. For the male there is but one contraceptive, the condom. For the female there are many:

diaphragms, pastes, and sponges, to mention a few. The male condom or sheath is made of rubber and is worn on the organ for the purpose of preventing the passage of semen into the female generative tract, thereby making it impossible for the spermatozoon ever to come in contact with the ovum. In the female the diaphragm is inserted in the vagina. It fits snugly in the vaginal passage in such a manner that it does not interfere with sexual congress; and the rubber surrounding the rim naturally divides the vagina into two parts, the part below the diaphragm and the part above the diaphragm. The section above the diaphragm includes the cervix of the uterus, through which the semen must pass to have the spermatozoon impregnate the ovum. The semen never gets beyond the rubber of the diaphragm, the idea being that if the diaphragm is perfectly fitted (and many times it is not), there is no likelihood of the semen reaching the canal of the cervix of the womb. These diaphragms can be inserted either by the patient herself or by a physician.

**Fallacies and Frauds in Contraception.** The makers of these diaphragms insist that they can and positively will prevent conception, but they also make pastes to be inserted in the vagina under pressure from a collapsible metal tube. The chemistry of the paste is such that it supposedly accomplishes two things: first, it "kills" the spermatozoa; secondly, it changes the chemistry of the vagina so as to help accomplish the same purpose. Pastes are advertised in two ways: the paste itself is supposed to prevent conception, although the patient is often told that it might be safer to use a diaphragm as well as the paste. Then there are



douches, acid in character, some of which supposedly contain a chemical to "kill" the spermatozoon; they too are supposed to make it impossible for conception to take place. Then again, many patients are told for perfect safety to use the diaphragm and the paste and the douche.

In an article written about 1940, *Fortune* Magazine said that the contraceptive industry at that time was a two-hundred-and-fifty-million dollar one. If that figure is accurate, it is, in our opinion, today nearer a one-billion dollar industry.

A perusal of reports from so-called "contraceptive clinics" will reveal that no clinic says that it gets one hundred per cent perfect results with its contraceptives. The highest figure we have ever seen is "97% per cent successes." Assuming that figure to be correct, one can easily get a 97 per cent so-called "successes" by following the rhythm method; and we believe that if the rhythm method is rigidly followed, the result can be 100 per cent successful.

Diaphragms, pastes, powders, and sponges cost a great deal. There is no charge for information about the rhythm method. The time may come when the world will know that the rhythm method is more efficacious than any contraceptive made and that the rhythm method costs nothing, but we fear it will be a long time before an industry that we think is a billion-dollar one will allow the world to know that they can do something else to accomplish the same end, the use of which is not contrary to God's law.



## CHAPTER EIGHT

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### ABOUT PSYCHIATRY

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PSYCHIATRY has become a byword in our language in recent years, as the recognition, treatment, and prevention of mental illness have emerged from the shadows of fear, the stigma of disgrace, and the hopelessness of apparent incurability, as did tuberculosis and cancer in an earlier generation. A newly renovated science, it has been accompanied by the usual exaggerated enthusiasms, unfounded hopes and fallacies, unethical appendages, and several varieties of pseudo-scientific psychologies. Underlying all this is a solid core of established knowledge, constantly increasing, with which all who deal with human problems should be acquainted. We will try to outline, although in a very sketchy manner, this body of truth.

#### PSYCHIATRY AND PSYCHIATRISTS

Psychiatry is a specialty within the medical profession, just as are obstetrics, gynecology, cardiology, surgery, etc. Psychiatry, etymologically, means the healing art or the art of medicine applied to the mind or soul. It is the branch

of the medical profession dealing with abnormal conditions or diseases which affect adversely the mental functions of man. Formerly, it had to do almost entirely with the care of the insane. The history of psychiatry during the past century is fascinating; and to those interested, we recommend the reading of the late edition of the classic *A Mind That Found Itself*, by Clifford Beers, the late respected founder of the Mental Hygiene Movement, and *The Mentally Ill in America*, by Albert Deutsch, a new edition of which has just been published.

Mental illness is caused by many different things. Among them are infections, injuries, poisons, tumors, arterial disease, brain degeneration, and disorders of bodily organs far removed from the brain. Many symptoms caused by these obviously "physical" conditions can be also caused by emotional stress arising from personal, family, school, social, business, military, moral, religious, and a host of other situations. Psychiatry has exerted its influence on all of these situations, and in many cases has aroused resentment on the part of those primarily concerned with non-medical human problems. It has also given rise to the attempted use of psychiatry by nonmedical persons and the impression that psychiatry is a field independent of the medical profession.

A psychiatrist is a physician, that is, a Doctor of Medicine, who has added to his fundamental medical education the further education and training necessary to qualify him as a specialist in this field. No one else can call himself a psychiatrist without exposing himself to suspicion of quackery. No one but a physician is qualified to recognize

and treat the physical causes of mental illness — and in no case of mental illness should a reasonable search for bodily disease be neglected. At the same time, his medical and psychiatric training does not qualify the psychiatrist to take over the moral, religious, and political direction of his patients. Emotional stress arising from moral and religious problems, as well as others, is now known to precipitate organic disease, such as stomach ulcers. This fact has brought about a new specialty in medicine or, perhaps better, within psychiatry, known as psychosomatic medicine. In the proper care of many cases the joint efforts of internist or surgeon, psychiatrist, and priest are needed.

## PSYCHIATRY AND PRIESTS

It is advisable for every priest to learn from psychiatry all he can about the emotional conflicts of people and the methods of helping to solve them. From psychiatry he can learn much to help him in performing the works of mercy, especially instructing the ignorant, counseling the doubtful and comforting the sorrowful. He is constantly called upon to give direction to persons afflicted with scrupulosity, which is a form of psychoneurosis. In his pastoral ministry he frequently meets persons who are psychotic, whom he should be able to recognize as such and direct to seek medical psychiatric advice. He should know, in general, why some children are retarded or are problem children and how to go about getting intelligent examination and advice for these children. He should be able to recognize "constitutional psychopaths," who are not considered insane, but

who cause a tremendous amount of unhappiness, suffering, and injustice. In all this and much more he can be greatly helped by psychiatry; but he should never allow himself to think that he is a psychiatrist or allow others to think so, unless, of course, he really is an M.D. with the necessary psychiatric training. Furthermore, he should not allow himself to be numbered either among the over-enthusiastic gullible who accept every claim made in the name of psychiatry, or among the ridiculers or condemners of everything psychiatric. Finally, he should respect those who are mentally ill and never think of them or refer to them in terms of contempt, such as "nuts."

## PSYCHIATRY AND PSYCHOLOGY

Psychiatry, like every field dealing with human problems, including education, sociology, political economy, religion, and even politics and industry, depends in part on psychology. *Human psychology* is the science and philosophy of human nature, its origin and destiny.

Psychology differs from other natural sciences like chemistry, physics, and biology in that there are many "schools" of psychology teaching different, and frequently conflicting concepts of human nature. As a result, similar conflicting concepts, with resulting confusion, are found in all the fields dependent on psychology, including psychiatry. In many psychiatric conditions, the advice given by the psychiatrist will depend largely upon his own convictions concerning the nature and destiny of man. Psychiatry itself has given rise to several new psychologies, the best known

of which at present is psychoanalytic psychology. More will be said of that later. If psychiatry is frequently criticized adversely, either in general or in some of its varieties, it is criticized largely because psychiatrists differ in their convictions concerning human nature and destiny. This difference of opinion results in confusion among themselves with respect to the purpose in view in treatment, and in misunderstanding on the part of the critics with respect to the relation between psychiatry and some of its highly publicized subdivisions and off-shoots. Our own concept of human nature and destiny has already been outlined in Chapter I.

## PSYCHIATRY AND INSANITY

Insanity and psychiatric disorders are far from being synonymous terms. Insanity is a legal term and is used by the psychiatrist only to satisfy the requirements of courts. It refers to any condition in which the victim, by reason of disease or abnormality, is *unable* to take care of his affairs in a sufficiently reasonable manner to avoid conflict with others or with the community, or serious injury to himself. Until the advent of psychiatry as a medical subject, the "insane" were cared for in the same manner as criminals, at least for the most part. At present, the care of the mentally ill who are not insane is occupying a constantly increasing proportion of the time of psychiatrists and psychiatric clinics.

## PSYCHOSES AND PSYCHONEUROSES

A psychosis is a disease which renders a person temporarily or permanently insane. Psychosis is a medical term.



It is possible for a person to have a psychosis and recover. It is possible for him to be for a long time not insane at all or not recognizably insane, or only very mildly mentally ill. There are many kinds of psychoses. For some of them the cause is a known physical condition such as infections, tumors, arterial or heart conditions, poisons and drugs, or injuries, especially to the brain or skull. For a large percentage of them the cause is unknown, especially schizophrenia and manic-depressive psychoses. These two forms of psychosis constitute one of the great mysteries of psychiatry.

The symptoms of schizophrenia are usually described as bizarre. They are, in effect, a "splitting" in the harmonious co-ordination between the knowledge (whether correct or delusional), the emotional feeling, and the behavior. Schizophrenia was formerly called *dementia praecox* because it was considered to begin in youth (precocious) and to be a progressive loss of mental health (*dementia*). It was also considered to be incurable and irrecoverable. Experience has shown that it sometimes begins in later life, that it may be partially or entirely curable, and that its victims sometimes recover spontaneously.

The symptoms of manic-depressive psychosis are more likely to arouse the sympathy of observers, because they usually resemble exaggerated forms of exhilaration or depression experienced by mentally normal people. It characteristically occurs in attacks of mania or depression, or both, at different times, or mixtures of both, sometimes with stupor or confusion, usually with normal intervals. The attacks commonly occur in cycles of one or several

varieties, and for this reason the psychosis is also called cyclothymia.

The psychoneuroses or neuroses include a wide variety of conditions which are considered to spring from "mental" or "emotional" conflict or stress. Occasionally, but not at all usually, they become serious enough to render the victim psychotic. The scope of this work does not permit a lengthy description of the types of neurosis. Probably the essence of most of them is a preoccupation with self. In fact, one of the best means of curing or preventing many of them is the cultivation of a preoccupation with the troubles of other people. One should be extremely careful about labeling any person "just a neurotic," since in any individual case the symptoms may be a perfectly natural reaction to some bodily disease or some environmental condition (family, school, social, occupational, etc.) which needs correction. The emotional experience causing a neurosis may be a prolonged one or it may be a single intense one. In the latter case, the experience itself may be forgotten by the patient, who can be greatly helped by recalling it and recognizing its influence on his or her emotional habits.

#### MENTAL DEFICIENCY (FEEBLEMINDEDNESS)

Mental deficiency is a condition in which the development of the mental faculties is arrested, usually because of a congenital defect which results in an immature brain. The congenital defect may be due to inherited defects in the parental germ cells or may be due to some disease affect-

ing the child before birth (intrauterine disease). Sometimes it is due to diseases during infancy which retard the development of the brain. Frequently, the immaturity of the brain is accompanied by a mature development of the rest of the body, so that the victim becomes an adult in all respects except with regard to his mentality. The mental development may stop at any age, resulting in idiocy, imbecility, or moronity of high or low grade, as the case may be.

The treatment of mental deficiency consists largely of the recognition on the part of others of the limitations of the person concerned, and of the accommodation of the demands upon him to his abilities, together with the education of those who come in contact with him as to the regulation of their own conduct toward him. It is not an uncommon practice to recommend institutional care for all feeble-minded children. Institutional care is necessary, of course, in cases in which the home is not suited for the bringing up of a feeble-minded child or in which the child as he reaches physical maturity becomes a threat to the safety of others. The claim is often made that the presence of a mentally deficient child in the family is detrimental to other children of the family. Whenever it is possible, however, we think that the mentally deficient child should be cared for within the family. For one thing, he may furnish to the other children an excellent opportunity to learn to care for the less fortunate and to bear responsibilities without embarrassment or unjustified shame. Mentally deficient children can learn far more than is commonly thought, as has been proven by many people engaged in their care who are able and willing to devote the time and

patience to teaching them. The study of retardation in the school career of children demonstrated long ago that retardation in school work is not necessarily due to mental deficiency, but may be due to unrecognized physical difficulties or diseases, family discord, broken homes, and various other causes. The late Dr. Walter Fernald, for whom the Fernald School at Waverley, Massachusetts, is named, who introduced in Massachusetts the practice of routine examination of retarded school children, considered the measurement of the intelligence quotient the least important in the ten points to be taken into consideration in the diagnosis of feeble-mindedness.

## MENTAL HYGIENE

Hygiene refers to the science of the preservation of health and the prevention of disease. The organized mental hygiene movement began with the work of Clifford Beers, who himself suffered from a psychosis during which he became well acquainted with the care of mental patients in the hospitals of his day and was inspired thereby to devote his life and fortune to the improvement of the care of the mentally ill. After recovering from his psychosis, he began with the organization of a mental hygiene committee in New Haven, Connecticut. His energy brought about the expansion of the mental hygiene movement with the formation in all of the states of the union of State Committees, which were united into a National Committee and culminated in the organization of an International Committee of Mental Hygiene. The progress of this movement and its truly great

accomplishments can be read in the latest editions of Mr. Beers' book, *A Mind That Found Itself*, to which reference has already been made. Here we content ourselves with recommending to young priests that they become reasonably acquainted with the aims and work of those engaged in the mental hygiene movement, so that they will be able to give them intelligent and sympathetic understanding and co-operation. This is especially true, since the workers in mental hygiene are exposed constantly to erroneous philosophies of human nature and, in most cases, sincerely want the help which can come only from supernatural sources.

## PSYCHOTHERAPY

The word therapy means treatment. Psychotherapy means treatment of abnormal conditions by mental means in contrast to treatment by drugs, baths, massage, institutional care, surgery, etc. Psychotherapy is one of many instruments in the equipment of the physician who treats mental illness or any other kind of illness. Psychotherapy, without being labeled as such, is used by physicians in all the divisions of medicine and is used by many others, including priests. Several formal techniques of psychotherapy have been developed, including the well-known technique of psychoanalysis. The psychotherapeutic technique begins with the establishment of what is called rapport, which essentially means placing the patient at his ease and winning his confidence. This is followed by the attempt, in one manner or another, to get the patient to understand



the nature and source of his difficulties and to bring about his own cure by the adaptation of himself to his circumstances or by changing his environment.

In the use of psychotherapy there is no substitute for time and patience. It is usually a long and arduous procedure and is not always subject to any hard and fast rule. The psychotherapist must, perforce, accommodate himself to the demands of the individual case. Economy of time has led in recent years to the development of what is known as group psychotherapy, which is especially applicable to the treatment of the psychoneuroses. In group psychotherapy a number of people gather together at intervals to listen to a short instruction from the psychotherapist and then to engage in a kind of get-acquainted meeting. The average neurotic person is inclined to think that he is the only one suffering from his particular trouble and that his condition is very noticeable to others. In the course of group psychotherapy he discovers that there are many others who suffer from the same symptoms and that their condition is not noticeable to others. This discovery is inclined to break the vicious circle which has aggravated his anxiety or fears and to initiate his improvement, if not recovery. Perhaps it is a good illustration of the old adage that "misery loves company."

## PSYCHOANALYSIS

Psychoanalysis has become so prominent in the field of psychiatry and also in all the other fields into which it has permeated that it is very commonly misidentified with

psychiatry. Psychiatry and psychoanalysis are not identical. Psychoanalysis was originated by the late Sigmund Freud as one form of psychotherapy. Its elaboration was due to Freud's desire to find some better method of treating psychoneurotic patients to replace the use of mesmerism and hypnotism. For a proper understanding of psychoanalysis one must distinguish between psychoanalysis as a method of treatment in mental illness, i.e., a medical technique, and psychoanalytic psychology, which is a philosophy of human nature (psychology) which developed as a result of the facts discovered by Freud and his followers in the practice of psychoanalytic technique. Briefly, according to psychoanalytic psychology, the human personality is made up of three parts, known as the ego, the superego, and the id. Freud began with the assertion that in every person there is an unconscious mind, which is independent of the conscious mind and which is the storehouse of repressed memories, urges, inclinations, etc., to which is attached energy called "libido," which is under tension and is, therefore, seeking escape from the tension. In his later modification of the theory the unconscious mind became the principal part of the "id." From the id there develops what is called the superego, which is identified in the psychoanalytic theory as the conscience. This superego, or so-called conscience, is the source of the moral sense or the guilt feelings and remorse which attend conscious inclinations to do what is taboo in society. The purpose aimed at in the psychoanalytic technic is the liberation of the ego from the tyranny of the superego. This means the abolition of the guilt feeling. According to psychoanalytic theory, *all* of the

behavior of the individual is controlled ultimately by the unconscious mind.

Correctly understood, the "moral sense," including both the guilt feeling and the feeling of satisfaction which accompanies acts of virtue, is emotional in nature. It is the result of the activity of that part of the brain known as the hypothalamus, just as vision is the result of the activity of that part of the brain known as the occipital area of the cerebral cortex. The emotional feelings are physical reactions. They can be conditioned or trained, either as the result of the deliberate effort of the individual, or as the result of the influence of environment. They are the accompaniment of acts of the will in the normal state, and the guilt feeling is a healthy response to the knowledge that one has willed what is contrary to Divine Law; but while they are an aid to conscience, they should never take the place of conscience. Conscience, in the correct meaning of the term, is the intellect when it is used to judge in matters of morality; and by morality we mean the natural or supernatural Divine Law, applied to human actions. Scrupulosity, for example, is a neurosis in which the guilt feeling becomes a response to actions which are not sinful, whereas laxity of conscience is a condition in which the guilt feeling is not present as a response when the facts would justify its presence.

Psychoanalytic psychology is a materialistic and deterministic philosophy of human nature. The psychoanalytic technique is a re-education of the patient to the conviction that there is no such thing as sin in the Judeo-Christian meaning of the word. Freud devoted three of his books

(*Civilization and Its Discontents*; *The Future of an Illusion*; and *Moses, Maimonides, and God*) to the thesis that religion is the cause of all the discontents of mankind and advocated its eradication from the world.

For a convincing demonstration that the psychoanalytic concept of man and the scholastic concept of man are irreconcilable, one can read *What Man Has Made of Man*, by Mortimer Adler (University of Chicago), with an introduction by Franz Alexander (Chicago Institute of Psychoanalysis).

Many people have been benefited by psychoanalysts. There is considerable truth mingled with the fundamental and subversive errors of the psychoanalytic philosophy of human nature. Otherwise, it would appeal to nobody. But all the truth and all the source of benefit can be found in any good psychotherapeutic technique. The growing knowledge of the functions of the brain are furnishing a more solid explanation of the influence of forgotten experiences upon human behavior.

Modern psychiatry has been and is constantly discovering new methods of treating mentally ill patients. Among them we can mention but a few concerning which people are likely to seek advice from the priest.

## CHEMOTHERAPY

Chemotherapy refers to the treatment of illnesses by drugs or other chemical means. In recent years the use of such drugs as sodium amytal to alter the mental functions temporarily, and especially to enable the examining physi-

cian to witness patients reliving intense emotional experiences and revealing facts which they do not reveal except under the influence of the drugs, has given rise to the question of the morality of the use of such drugs.

Obviously, it would be immoral to use them merely to discover secrets which the patient has the right or the duty to keep. There is no objection to their use by properly qualified and *conscientious* physicians when the knowledge gained is to be used to help the patient's recovery and when the confidence of the patient is respected as a professional secret.

## SHOCK TREATMENT

The so-called "shock treatment" in psychiatry has become well known to the public and widespread in its use. The shock treatment originated with the discovery that excessive doses of insulin administered to psychotic patients who also suffered from diabetes frequently resulted in amelioration of the psychotic symptoms. Excessive doses of insulin cause "insulin shock," which can be relieved by the administration of sugar, either intravenously or by mouth, or by orange juice. Experimental trial of intentionally produced insulin coma in other psychotic patients led to their improvement in many cases. Following this, the effort to discover some more easily controlled kind of shock led first to the use of the drug metrazol, and later to the passage of an electric current through the brain, a treatment which is known as the "electric shock treatment."

In the early days of the use of shock treatment, many



accidental fractures occurred because of the violence of the convulsion induced by the shock. At present, methods (especially the preliminary injection of certain drugs) have been devised to control the muscular contractions and to prevent the occurrence of fractures almost entirely. Like all newly discovered therapies, the electric shock treatment has probably been used over-enthusiastically by many psychiatrists; but in the hands of prudent men it has been followed by the complete or partial cure of thousands of mentally ill people, who previously would have been considered hopelessly and permanently psychotic. It has also proven extremely useful in hastening the recovery of many persons afflicted with serious psychoneurotic conditions. Again, in the hands of competent and conscientious physicians it is an ethically unobjectionable form of treatment, and priests may safely encourage patients and their families in consenting to its use in such hands.

## PSYCHOSURGERY

Psychosurgery refers to the use on the brain of certain surgical procedures designed to relieve symptoms and signs of certain of the psychoses, some psychoneuroses, and also cases of extreme continued pain which have proven intractable to the usual methods of controlling pain. The surgical operations falling under this title are chiefly pre-frontal lobotomy, leukotomy, and topectomy.

This is not the place to discuss the technique of these operations. Lobotomy and leukotomy are operations designed to sever the nerve fiber paths connecting certain

portions of the cerebral cortex of the frontal lobe of the brain with the thalamic area, which is the center of emotional experience and which controls emotional expression and behavior. The frontal lobe of the brain is frequently considered to be the seat of intellectual life, especially by those who do not subscribe to the spirituality of the intellect, properly so-called. Actually, it is probably the part of the brain which chiefly serves the functions of perception, sensory memory, and imagination, which are prerequisites for thought.

According to present-day conceptions of the functions of these parts of the brain, emotional feeling and impulses, together with their physiological activities in the heart, blood vessels, digestive system, etc., can be conditioned or trained in such a way that the emotions are aroused by the activity of the imagination or sense memory, which involves activity of the frontal cortex. The purpose of lobotomy, leukotomy, or topectomy is to destroy the influence of the imagination or memory on the emotional centers in the thalamic area; and in many cases it succeeds in doing so. At the same time, it commonly leaves the patient with personality changes of a serious nature, especially in regard to serious interest in his past and in the use of good judgment concerning the future, which is commonly called "fore-sight."

Topectomy is the surgical removal of part of the cerebral cortex itself (that is, the gray matter). In this operation the nerve cell bodies (whose fibers are severed in lobotomy or leukotomy) are themselves removed, the area to be removed being carefully selected and more or less accurately

defined — the selection being based upon the accumulated knowledge of the topography of the cerebral cortex and the connection with other parts of the brain and body, especially by the nerve fibers. The results aimed at and accomplished in the psychoses are the same as those aimed at and accomplished in lobotomy and leukotomy, and the operation permits of more accuracy. In the treatment of intractable pain, the results as reported have been good and have probably prevented a great deal of dependency upon the use of opiates.

These operations are mutilating operations and, therefore, are subject to the same moral laws which pertain to any kind of mutilating operations. They should be used only when there is a proportionately serious reason, when less mutilating methods designed to obtain the result have proven of no avail, and when their use promises a good result, proportionately as great or greater than the evil effect, and, finally, only under the control of competent and conscientious physicians.

In our opinion "psychosurgery" is an unfortunate term, since its use could easily increase in the minds of the unthinking the credibility of the materialistic doctrine that the brain furnishes the entire explanation of not only the sensory functions of man, but also all his intellectual functions properly so-called. It connotes the identity of mind and brain.

#### PSYCHIATRY AND THE CONFESSIONAL

There is a not uncommon impression that the priest in the confessional accomplishes the same purpose for which

many people go to the psychiatrist. This impression is not only widespread among lay people, but is also sufficiently prevalent among psychiatrists to warrant some comment and clarification. It is true that persons going to sacramental confession, emotionally disturbed because of the burden of guilt for real sin, experience great emotional relief after confessing their sins and receiving sacramental absolution. The same is true of people who suffer from guilt feelings because of error on their part concerning the factual sinfulness of some actions. The emotional relief experienced by people who unburden themselves to anyone concerning errors or sins on their part has always been recognized. Its common recognition is illustrated in such expressions as "the murderer always returns to the scene of his crime" and "confession is good for the soul." This method of bringing about relief from pent-up anxiety and guilt feelings was dignified in the early days of psychoanalysis by the title "mental catharsis." Mental catharsis, however, is only one of the many tools in the armamentarium of the psychiatrist, and in his hands it is a purely natural instrument. The psychiatrist can forgive no sins. On the other hand, the confessional is a place for the administration of the Sacrament of Penance. The Sacrament of Penance is one of the seven signs instituted by Christ to give grace. The confessional is a court in the supernatural order where the penitent brings himself to accuse himself of his own sins and to convince the priest who sits in judgment that he is honestly sorry for them and honestly determined not to commit them again. His confession is followed by the sentence of forgiveness, known as

absolution, on the part of the priest. The contrite confession of the penitent and the absolution of the priest may be followed by emotional relief or joy, but that is not the primary purpose of the confessional. The confessional is not a psychiatric clinic, and the priest is not a psychiatrist.

The priest, especially acting as Confessor, is called a "physician of souls." This expression means that, in addition to his function as a judge in the supernatural order and as an agent of Christ in administering the Sacrament of Penance, he also has the function of teaching, correcting, and consoling those who come to him burdened with guilt and with contrition for sin. He must give counsel and advice to those who come disturbed by moral and other problems connected with their daily lives. He must give instruction in all the methods of avoiding unnecessary contact with the occasions of sin, and he must be prepared to give wise and prudent advice to those who seek to rise to heights of true sanctity. These are his functions as a "physician of souls." This does not mean that he is qualified to undertake the medical psychiatric treatment of pathological cases.

Perhaps a final note of warning should be sounded concerning psychiatry and religion. Since the dawn of the twentieth century psychiatry has joined other branches of medical science, together with the other sciences, in making rapid progress in the understanding and treatment of mental illness and emotional stress. Its influence has been felt in every phase of life. In the meantime, for several hundred years, a large proportion of the people of what we call "Western Civilization" have had progressively less and



less instruction in the true faith, and less and less opportunity to profit by the supernatural effects of the sacramental system instituted by Christ. In the loss of this knowledge and the loss of the use of the Sacraments, they are left with a poorly defined conviction that something is seriously lacking in the direction of their lives toward a proper goal. To satisfy this need for something they do not know, they turn from one quest to another, and in our day they turn particularly to psychiatry, always looking for the answer to questions about their own nature and destiny.

A certain number of psychiatrists and a certain type of psychiatric teaching, especially the psychoanalytic, has made an effort, perhaps subjectively honest in great part, to provide a purely natural answer to this restless search for an unknown God. To a large extent, what is frequently miscalled "psychiatry" has become a substitute for religion; and there is the ever-present danger that Catholic scholars, in their effort to take advantage of all scientific discoveries and to avoid appearing anti-scientific, may be enticed into the error of attempting to reconcile false doctrine concerning human nature and destiny with the truth.

MEDICAL EXAMINATION AND  
TESTIMONY FOR ECCLESIASTICAL  
MATRIMONIAL COURT PROCEDURE

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THE DIOCESAN MATRIMONIAL COURTS of the Church exist to conduct investigations and arrive at decisions regarding the validity of particular marriages which have been called into question, and to investigate the circumstances and causes in those cases where dissolution of the marriage is possible without adversely affecting the public good (see Chapter I).

In certain types of cases, medical examination and testimony are necessary to assist the Court in arriving at a decision. The cases in which such examination and testimony are necessary fall under three headings, namely,

*a.* Cases in which dissolution of marriage is requested on the ground that a ratified Christian marriage has never been consummated. This type of marriage is technically known as unconsummated marriage. This means that the contract of matrimony has been entered into but has never been followed by sexual intercourse between the parties.

*b.* Cases in which the impediment of impotency is alleged.

c. Cases in which a mental disease allegedly interfered with the ability of one of the parties to make the contract of matrimony. These cases are outside the scope of this work.

## MATRIMONIUM RATUM ET NON CONSUMMATUM

The Church has never and can never change its teaching that a Christian marriage which has been ratified and consummated cannot be dissolved by any human power for any reason. It is dissolved only by the death of one of the parties. This refusal to recognize divorce with the right of remarriage among Christians originates in the Divine Law and is not subject to the power of the Church. There are, however, two ways in which an unconsummated Christian marriage can be dissolved. According to Ecclesiastical Law (Council of Trent, S.24, C-6), such a marriage is automatically dissolved by a solemn religious profession, that is, by the taking of solemn perpetual vows in a religious order. An unconsummated marriage can also be dissolved by papal dispensation when a sufficient reason, for example, incurable incompatibility, the public good, suspected impotency, civil divorce, contagious disease, and so forth (Canon 1963), exists.

Before an unconsummated marriage can be dissolved by papal dispensation, convincing evidence must be presented that sexual intercourse in the strict sense has not taken place. Two possible methods of proving that such is the case are recognized by Ecclesiastical Law. One is the testi-

mony of a number of reliable witnesses that the parties concerned have had no opportunity since the marriage ceremony to come together in sexual congress or that discord between them of such a nature as to preclude intercourse has existed from the beginning of the marriage. Such cases are indeed rare, as can be readily appreciated. They are possible, however, and have occurred, for example, in cases of so-called "forced" marriage in which the parties separate immediately after the ceremony and never cohabit. A marriage contract entered into under force is, of course, no marriage at all.

The other acceptable method of proof of nonconsummation is based on medical testimony. It is this medical testimony, and the examinations on which it is based, in which we are interested particularly in this section.

**Concept of Physical Virginity.** To understand the type of medical examination and the facts which the Court seeks in attempting to arrive at decisions in these cases, it is necessary to clarify concepts regarding what constitutes sexual intercourse. Confusion can easily result from the fact that the medical witness may have a different concept of what constitutes sexual intercourse than that set forth in Ecclesiastical Law. According to the traditional teaching of the Church, marriage is consummated only by complete sexual congress, that is, sexual congress with penetration of the entrance to the vagina by the male organ and the depositing of true seminal fluid in the vagina. True seminal fluid is fluid ejaculated from the penis, containing the output of the testicle and presumably containing spermatozoa. The problem arising from the distinction between ability

to copulate and ability to generate offspring will be discussed in a subsequent section of this chapter, under the heading of "Impotency." Here we discuss only the examination necessary for the determination of the consummation of marriage.

The medical examination for Matrimonial Court evidence in these cases is concerned only with the hymen and the hymeneal ring. The value of the evidence is based upon the fact that either the hymen is ruptured or the hymeneal ring considerably and permanently stretched at the time that the woman experiences her first intercourse. The virginal hymen, as described in Chapter II, is a membrane which surrounds the entrance into the vagina. Rarely, the hymen is a membrane containing no openings whatever (imperforate). When such is the case, an opening must be made in it at the first menstruation so that the menstrual fluid may escape. In most women, however, the virginal hymen has an opening, easily recognizable to the medical examiner. In the terminology of the Church, the existence of an intact hymen, that is, a hymen which has not been ruptured or one whose opening has not been penetrated or stretched, constitutes what is called physical virginity and is so accepted by the Matrimonial Court as evidence of intact physical virginity.

This concept of virginity differs somewhat from the commonly accepted medical concept of virginity. It is quite possible for incomplete intercourse, in which there has been no penetration of the entrance to the vagina, to be followed by pregnancy, in which case certain other medical signs are considered to be evidence of the absence or loss of vir-



ginity; for example, from the medical point of view evidence of loss of virginity may be found not only in the presence of changes in the hymeneal ring, but also in certain lacerations of the uterine cervix in women who have delivered children and, in cases of existing pregnancy, in the enlargement of the uterus found by abdominal and rectal examinations, the changes in the breasts, the other changes described in Chapter III, and the results of the Aschheim-Zondek test of the urine (or blood).

**Loss of Physical Signs of Virginity.** To add to the difficulties met in attempting to prove that a marriage has not been consummated, there are several things besides consummation of a marriage which can destroy the intact condition of the hymen and the hymeneal ring, making it impossible for the medical examiner to testify that physical virginity is intact. The principal causes for this condition are as follows:

*a.* Premarital intercourse, or intercourse with or without subsequent pregnancy during a previous marriage. Obviously, in such instances the physical examination is valueless as far as establishing evidence of nonconsummation is concerned.

*b.* Accidental injuries to the hymen or hymeneal ring in the course of recreation. Frequently, accidents during recreation result in injury to the external genitalia which renders it impossible to prove subsequently by medical examination that virginity has been preserved.

*c.* Medical and surgical examination and treatment. It is sometimes necessary to carry out vaginal examinations or treatments for conditions which have no relation to

sexual intercourse whatsoever, and such examinations or treatments may necessitate rupture of the hymen and stretching of the hymeneal ring. For example, the treatment of infection by the trichimonad vaginalis, a nonvenereal infection, or the performance of a uterine curettage for the treatment of certain menstrual disorders necessarily involves destruction of physical evidence of virginity. In one case which we have seen, a woman was examined with regard to establishing evidence of nonconsummation of her marriage. All of the nonmedical testimony supported the contention that the woman and her husband had never been able to have complete sexual intercourse, the husband being unable to penetrate the vaginal entrance. On the advice of a well-meaning physician, the wife had had the hymeneal ring artificially dilated, hoping that doing so might make it possible for the marriage to be consummated. This hoped-for result, however, had not been obtained; but the dilation had destroyed the material evidence of physical virginity.

*d.* The use of mechanical contrivances, known as pessaries, for correction of misplaced or bent uterus. These contrivances must be inserted in the vagina, and such insertion involves either rupture of the hymen or stretching of the hymeneal ring.

*e.* Certain modifications of menstrual napkins. Among the commercial appliances on the market to be worn during menstruation for collection of the menstrual debris are some which are designed to be inserted into the vagina. At least one widely advertised contrivance of this sort cannot possibly be used without destroying all physical evi-

dence of virginity at its first use, not to speak of the fact that its use could easily be the occasion of precipitating immoral practices on the part of the youthful user.

f. Certain mechanical devices for masturbation. Discussion of these is unnecessary for our purpose here.

**Pregnancy Occurring without Loss of Physical Virginity.** The traditional teaching of theologians that sexual intercourse means the penetration of the opening of the vagina, with the deposit of true seminal fluid in the vagina, leaves us, in a number of cases, in the position of contending that a woman who is actually pregnant nevertheless retains her physical virginity. It has long been known that seminal fluid deposited outside the vagina on the external genitalia is capable of penetrating the normal opening in the intact hymen, making its way through the vagina, uterus, and tubes, and finally fertilizing the ovum. In such cases, after the most careful and painstaking examination, the medical examiner can make oath that in his opinion there has never been a penetration of the hymeneal ring in spite of the fact that the patient is obviously pregnant. We can tell of a case of a woman who, if she had been delivered by cesarean section, could have defied anyone to find evidence of lack of virginity on her part, regardless of the fact that she was the mother of a baby. The man in this case frankly acknowledged that he had purposely avoided penetration or even any contact with the hymeneal orifice. The woman was examined three months later and found pregnant, with a perfectly normal virginal introitus.

More recently one of the authors of this book was asked to testify in court in a case of illegitimacy where the male

concerned acknowledged that there had been "intimacy," but that in order to make sure the female involved would not become pregnant the undergarment worn by her had purposely not been removed. The writer was asked in court to express an opinion as to whether or not it was possible for a woman to become pregnant under such circumstances. The female involved had already given birth to a baby about 8½ months after the alleged and agreed-to intimacy. His reply on the witness stand was that not only was it possible for pregnancy to result from such a congress, but, assuming that she was telling the truth when she testified that at no other time in her life had there been either real penetration or any such episode as above described, it would appear certain that the pregnancy resulted regardless of an undergarment having been deliberately worn in order to avoid pregnancy. Seminal fluid was ejaculated on that garment, this seminal fluid finally entered through the hymeneal ring into the vaginal cavity, and impregnation took place.

Another case involved a felonious assault on a fourteen-year old girl by four different males, three of them youths about eighteen years of age and one a married man about thirty-five years of age. Three of the four men involved acknowledged that they had assaulted the girl. Within a few hours of the time of the assault the girl was taken to one of our best hospitals, where, with the exception of a slight redness around the genitalia, it was impossible to find any true evidence of the assault. She was seen again at the same hospital within a period of forty-eight hours, at which time the slight evidence (redness) existing at the first ex-



amination had disappeared. When the case went to trial some three months later, one of us was asked to examine the girl in order to determine whether or not there had been a penetration of the hymeneal ring. Strange as it may seem, the only opinion that could be expressed was that it was not possible for one to say that there had been penetration. This young girl, then, had she become pregnant as the result of the four felonious assaults, each shortly after the other, nevertheless would have presented on examination incontrovertible signs of physical virginity.

A young unmarried woman was admitted to the hospital because of a tumor, which rose in her abdominal cavity to the height of the umbilicus (or navel). It was impossible to determine definitely by rectal examination what the nature of this tumor was, with the result that she was examined vaginally. Unfortunately, no record was kept of the condition of the hymeneal ring at the time of this first examination. As a result of this vaginal examination, a diagnosis of pregnancy was made; and, in order that the diagnosis might be corroborated, several more vaginal examinations were made. Finally, the girl was told that she was pregnant. She insisted that such a thing was impossible, since she had never had sexual congress with anybody. At the time, although not engaged to a particular young man, she nevertheless was keeping company with one; and both knew that sooner or later there would be a formal announcement of their engagement. This young man insisted, too, that in so far as he was concerned, it was absolutely impossible for him to be the father of the child, since he had never had sexual congress with the young woman. However, being



very much in love, he consented to marriage — a forced marriage. Unfortunately, this episode happened before the days of the Aschheim-Zondek test, or it would have been a very easy matter to determine fairly accurately whether or not the diagnosis was correct. One month, two months, nine months later, the abdominal tumor was of the same size because the tumor was a fibroid tumor of the uterus from the start, and never a pregnancy. The girl was really a virgin on the day of her forced marriage, and her apparently positive signs of lack of virginity were due to the numerous pelvic examinations.

## IMPOTENCY

Impotency is the lack of power to have normal sexual intercourse. Impotency is to be distinguished from sterility, which is the absence of the power of generating children. Impotency is absolute if the individual lacks power to have intercourse at all. It is relative if he or she has power to have intercourse, but not with his or her spouse.

**Impotency in the Female.** One meets this problem in the female far less frequently than in the male. It should be remembered that in the act of copulation the male may be designated as the active participant and the female as the passive participant. Very rarely in the practice of medicine one sees a female who is impotent because, owing to some abnormality of development in intrauterine life, she has been born either without a vagina or with a vagina in which one wall is adherent to the other, so that it is impossible for her to have sexual congress. Very rarely, also,

a patient may have an imperforate hymen, that is, a hymen without any opening into the vaginal cavity. If there is an absence of the vagina but a normal introitus and normal tubes, uterus, and ovaries, it is possible by surgical method to form an artificial vagina. Other than to say that the procedure consists of bringing down a loop of bowel from the abdominal cavity to the introitus and then by different "stages" making an artificial vagina, it does not seem necessary in a book of this type to discuss such an operative procedure at any greater length.

If the impotency is due to the fact that the hymen is imperforate, it is a very easy matter to make an opening, thereby easily and for all time overcoming that cause of impotency.

If a woman has a normal vagina, it is impossible for her to be absolutely impotent. It cannot be said of her that she is absolutely impotent even if during her entire married lifetime she has never experienced any sexual feeling as a result of intercourse. There are many who are likely to call a woman impotent because she does not experience any feeling at the time of copulation. It can truthfully be said that there are millions of mothers who have raised large families, but who have never experienced any sexual sensation.

There is a condition commonly called "vaginismus" which is perhaps the most frequent cause of relative impotency in women. The vaginismus may be due to faulty but not wholly abnormal development in intrauterine life, or may be due to "psychic" causes. These so-called psychic causes may further be classified as those that are positively

due to faulty nerve supply, and those due simply to fear on the part of the female that sexual intercourse is going to cause pain or other distress. Vaginismus, causing a relative impotency, is occasionally due to the fact that a patient has taken douches of a kind to cause astringency of the mucous membrane (lining) of the whole vagina, thereby making normal sexual relations difficult. Priests, psychiatrists, and gynecologists may occasionally see a patient who is relatively impotent because of her distaste of the marital act. Certain impairments of the central nervous system may conceivably cause permanent or temporary impotency.

Although vaginismus explains the great majority of cases, relative impotency is occasionally caused by a caruncular condition of the meatus of the urethra, that is, a prolapse (falling) of the lining of the urinary passage, which has caused relations to be painful and, consequently, feared. The result is that there is no further desire for sexual congress until the condition is corrected by medical treatment.

In some cases of endocrine disturbances which result in a condition spoken of as infantilism, the uterus is smaller than normal and the vagina shorter than normal, the vagina being so short, in fact, and the cervix of the uterus so low, that they constitute an obstruction, resulting in relative impotency. Since it is possible for there to be penetration, a condition of this kind cannot be classified as absolute impotency; nevertheless, it must be borne in mind that there is every chance that the condition will be permanent and that such a woman will continue permanently to be relatively impotent.

Owing to a malposition of the uterus, or a prolapse (falling of the womb), there may be obstruction to complete insertion of the penis because of pain experienced by the female. This condition can be easily remedied by operation and is classified as relative impotency only until that time when the condition is corrected by operation.

One occasionally sees a female patient who is anatomically normal in so far as her sex organs are concerned, but whose husband is of such size that it is difficult for her to have satisfactory normal relations. They, then, are relatively impotent in regard to each other.

**Impotency in the Male.** Impotency in the male is much more common than in the female. It will be remembered that intercourse in the proper meaning of the term consists of penetration and the deposit of semen in the vagina. Therefore, if a physical condition of the man makes it impossible for him to penetrate the vagina and then ejaculate semen in it, he is classified as impotent. The number of causes of impotency, therefore, is greater in the case of the male than in the case of the female. They may be summarized as follows:

*a.* The absence of a penis, because of congenital or traumatic conditions.

*b.* The absence of the power of erectility or the power of ejaculation. Such a condition may be due to certain diseases of the spinal cord, which interfere with the proper function of the nerves which control sexual activity. Such a condition may be temporary or permanent, depending upon the nature of the disease in the individual case. It is usual in paraplegics, who are now fairly numerous as a

result of injuries in World War II. One case has been reported to us in which a married paraplegic succeeded in becoming the father of a child in the natural manner. This case appears to indicate that some paraplegics can validly marry. The question of invalidity of a paraplegic's marriage on grounds of impotency would have to be decided in the individual case.

*c.* Certain diseases of the central nervous system, particularly the spinal cord, sometimes cause continuous penile erection (priapism) which allows of penetration but not ejaculation. Since in such cases the deposit of seminal fluid in the vagina is impossible, the patient is impotent. These conditions are sometimes curable by surgical procedures, as, for example, in the case of certain tumors of the spinal cord.

*d.* Temporary impotency may be caused by sexual exhaustion from excessive indulgence in intercourse or from persistent and frequent masturbation. Such temporary impotency is obviously amenable to treatment.

*e.* Impotency in the theological meaning of the word results from the removal of both testicles or from the operation known as "double vasectomy" in which the tubes which convey the semen from the testicle to the ejaculatory apparatus are closed or cut. This operation is the common means used to sterilize the male. Obviously, in these cases true seminal fluid cannot be transferred from the testicle to the ejaculatory ducts and therefore cannot be deposited in the vagina. Such a patient, although he is called potent in medical terminology, is nevertheless at least probably impotent in the theological meaning of the word.



We call the attention of the reader here to a fact which is further discussed in another part of this work. Since marriage is consummated only by true sexual intercourse between husband and wife, that is, intercourse in which true semen is deposited in the vagina, in those cases where husband and wife from the beginning of their marriage practice contraception either by withdrawal before ejaculation or by wearing the common type of condom for the male, they do not consummate marriage. Probably every physician, if not every confessor, knows that there are many such cases, although the nonconsummation would probably be very difficult of proof in a matrimonial court. Such cases are rarely accepted for hearing by the Courts.

#### A NOTE ON ORGASM

We realize that it is difficult to discuss this delicate matter even in a book such as this. We do it, however, because of our desire to help the priest in advising in such cases. Many married males have found themselves both worried and discouraged about their early marital life until the true physiology of male coition has been explained to them.

In advising those persons who complain of the absence of an orgasm, it is well to consider what we will call the "physiology of coitus," as it pertains to the male. This so-called "physiology" may be divided into five stages:

(1) excitability, (2) erectility, (3) insertion, (4) ejaculation (orgasm), and (5) flaccidity and withdrawal. (The withdrawal may be described as being involuntary, since the organ withdraws itself due to flaccidity and without any muscular effort on the part of the male.)

It must be borne in mind, then, that after the male has

experienced his orgasm, there is but little, if anything, that he can do "coitionally" to help further in the orgasm of his wife. The male orgasm (ejaculation) is quickly followed by the beginning of flaccidity, a stage which starts shortly after the end of the orgasm. He cannot have another orgasm until there is another complete five-stage coitus; and this, it may be said, is impossible until thirty minutes to two hours have elapsed, the length of time varying with the individual. He may be able to help in the orgasm of his wife by osculation or other means.

It should be obvious, then, that any coitional help given by the male to the female to bring on an orgasm must be given prior to or during his own and cannot be expected to be "post-ejaculational." Both husband and wife should be advised to make every effort within their control to perform the marital act slowly and gently, rather than quickly and "brutally."

## MENTAL DEFICIENCY AND INSANITY

The discussion of evidence of these conditions as causes for the invalidity of marriage contracts is beyond the scope of this work. It will suffice to state here that it is necessary, when the claim is made, to prove that the mental condition of the party alleged to be insane or defective was such *at the time of the matrimonial contract* as to render him or her at that time incapable of understanding or freely making such a contract. Here again the requirements of the Church differ from those of civil authority, where mental deficiency or insanity preceding or following the marriage may constitute grounds for declaration of nullity or divorce.

## BAPTISM AND EXTREME UNCTION

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SINCE this book is intended for physicians as well as for priests, we include a chapter concerning two other sacraments, Baptism and Extreme Unction. Even at the risk of offending some of our readers by the intimation that they may not know all about Baptism and Extreme Unction, we will begin by reminding them of the simple definitions of these sacraments, hoping that our words will reach the eyes of some who either have not known these or have forgotten some of them.

A sacrament is a sign perceptible through the senses, instituted by Christ for the purpose of giving or increasing sanctifying grace. With no disrespect, the Sacraments may be compared to the units of paper currency which are signs instituted by the civil authority and which have a value, because of that authority, ordinarily possessed by articles of intrinsic value. It is important to note, however, that the Sacraments themselves actually produce what they signify. Christ instituted seven Sacraments, and of these seven, Baptism is intended for the beginning of Christian

life and Extreme Unction for the termination of Christian life as far as our temporal existence is concerned. The effects of the Sacraments are supernatural because of the power attached to them by God Himself.

## BAPTISM — WHEN AND HOW TO BAPTIZE

Baptism is a Sacrament by which a human being is initiated into membership in the Church of Christ. By it the inherited guilt of original sin is eliminated or “washed away” by the infusion of sanctifying grace. Sanctifying grace is a gift of God which makes the human being an adopted child of God and heir of Heaven.

Baptism can be conferred in case of necessity and in danger of death by anybody, Catholic or non-Catholic, pagan, Jew, or infidel, man, woman, or child, provided he has the use of reason and intends to do what Christ intended or what the Church does in Baptism. However, a Catholic should baptize if one is available, or a baptized person in preference to one who is not baptized. It is important, therefore, that all should know how to baptize, since the need may arise at any time; and unless the rite is performed correctly and with the proper intention, there is no Baptism. Non-Catholic physicians and nurses, therefore, should know how to baptize, not only because of their moral obligation to do so, but also in order that they may satisfy, when occasion arises, the legitimate desires of their patients to have their progeny baptized. Since reverence for the Sacraments and the fact that their ministry is exercised in the name of Christ and His Church demands that the min-



ister of a Sacrament should be free from mortal sin, he should make an act of contrition before giving Baptism, although it is not required for validity.

The person who confers Baptism does so by pouring water upon the body of the person to be baptized (upon the head, if possible) and saying while pouring the water: "I baptize thee in the name of the Father and of the Son and of the Holy Ghost." The word "Amen" is not to be used, although its addition would not invalidate the Sacrament. The water used may be any water, but, if possible, the baptismal water especially blessed by the Church for the purpose should be used, and respect for the Sacrament demands that clean water be used in preference to contaminated water. Obviously, in certain circumstances, such as the circumstances surrounding abdominal operations, sterile water should be used if possible. The words must be exactly those quoted above and must be said, not before or after the water is poured, but while it is poured. At least enough water must be used to flow over some portion of the person being baptized.

The priest is the ordinary minister of Baptism and therefore should be called if practicable, even at the cost of some inconvenience. In any event, the person who is baptized in danger of death should afterwards be referred to the priest, particularly so that the Baptism can be recorded and the other ceremonies supplied, and also so that the priest may investigate to insure that Baptism has been conferred correctly. We emphasize this because we have known of cases in which, with the best of intentions on the part of physicians and nurses, it has been demonstrated that the



Baptism had been conferred invalidly because of either excitement or ignorance on the part of the baptizer. For example, in one case a priest was called during the night to a hospital to baptize an infant delivered by cesarean section, and in some danger of death. When he arrived, the nurse who had called him was being gently reprimanded by another nurse, who said there was no need of calling the priest, because she had baptized the baby. The priest then, following his routine, questioned her as to what she had done. She replied that she had poured water upon the head of the baby and while pouring it had said: "In the name of the Father and of the Son and of the Holy Ghost." Further questioning confirmed the fact that she had omitted the words, "I baptize thee." The priest thereupon baptized the baby, who subsequently died. If the priest had been allowed to spend the night undisturbed, the baby would have died unbaptized in spite of the good intentions of the nurse.

Baptism should be conferred upon any baby who is certainly going to die, or any baby in danger of death, born of Catholic parents or whose parents, even though non-Catholic, wish to bring the child up as a Catholic if it lives. In the case of Catholics, the danger does not have to be immediate to warrant immediate Baptism, nor does the danger have to be apparently very serious as long as there is any danger. To illustrate this point we describe the following case. One of us was called to a home and asked to baptize a baby belonging to a Catholic family, the baby being already several months old and Baptism having been postponed awaiting the arrival from a distant point of the

prospective godparents. This postponement of Baptism, incidentally, is prohibited by the Church, since all babies should be baptized soon after birth (within a few weeks) even though not in any danger. In this case the baby to ordinary appearances was healthy, although it had been sick during the afternoon. A physician had been called, and he stated that the baby had been sick but was better and apparently all right. The priest explained at length to the family the teaching of the Church concerning Baptism, and the obligation of parents to have their children baptized within the first few weeks, the rule being that children not in danger of death must be brought to the Church to be baptized. He was about to take his departure, leaving instructions that the child be brought to the Church for Baptism in accordance with the regulations. Before leaving, however, it occurred to him that infants who are in any way sick frequently surprise all concerned, including the physician, by dying, thus demonstrating that they are sicker than they appear to be. To be on the safe side, therefore, he baptized the baby and left, still leaving instructions that the baby should be brought to the Church to have the ceremony completed and the Baptism recorded. The following morning he visited the home and found that the baby had died during the night.

In the case of abortion and miscarriage, whether spontaneous or induced, the embryo or fetus should always be baptized immediately. If the embryo or fetus is apparently dead, it should be baptized conditionally; that is to say, the person baptizing him should have the condition in his mind or he may express it: "if thou art 'capable' " or, in

this case, "if thou art alive." It should be borne in mind that it is necessary to pour the water upon the individual to be baptized; and, therefore, if the membranes surrounding the embryo or fetus are intact, they must be opened and the water poured directly upon the embryo or fetus, or the embryo or fetus exposed by opening the membranes may be immersed in a basin of water while the words of Baptism are recited.

In case there is doubt whether the expelled or removed uterine content contains an ovum or fetus, such content may be baptized conditionally, the condition being "if thou art capable of being baptized."

In the event that a child who is baptized in a hospital or at home or elsewhere while in danger of death recovers, the parents or guardians should be instructed that they are to bring the child to their parish church later in order to have the solemn ceremonies accompanying Baptism carried out and the Baptism recorded in the parish records.

Some textbooks of medical ethics devote considerable space to the discussion of intrauterine Baptism. We wish to call attention to the fact that no fetus can be baptized unless water is poured directly upon the fetal body, preferably the head. This cannot be done unless the membranes are ruptured. The membranes cannot be ruptured unless the os is dilated. The dilatation of the os is initiated by uterine contractions which result in the expulsion of the uterine contents. If the child has not reached the period of viability, this means that a miscarriage has begun. In other words, a child can be baptized while still in the uterus only during the process of delivery and after the

membranes are ruptured. From the practical point of view, intrauterine Baptism is to be considered only in cases of difficult labor where the membranes have ruptured and the child's head or other part is presenting through the dilated os and there is question as to whether the child will live long enough to be baptized after delivery.

Some few years ago one of us was called to a hospital at the request of a patient who had previously been shot with murderous intent. The bullet had completely severed her spinal cord at about the fourth dorsal vertebra. At the time, she was 5½ months pregnant. She had been told by the surgeon in charge that in all probability she would die and that death would ensue in a matter of days. The patient was a devout Catholic and, having been told that she was to die, immediately expressed a desire to have her unborn 23-week fetus baptized. Since the Baptism would not be valid unless the baptismal water had come in contact with the body of the fetus and this could not happen unless the membranes had previously been ruptured, and since the child had not reached the age of viability, Baptism could not be administered. We are glad to report that the patient did not die until three months after the delivery of her baby at term, the delivery having been painless.<sup>1</sup> At birth the baby was baptized by the Catholic hospital chaplain.

#### EXTREME UNCTION

Extreme Unction is a sacrament by which a baptized Catholic receives his final preparation for death, as far as

<sup>1</sup>F. L. Good, "Pregnancy and labor complicated by diseases and injuries of the spinal cord." *J. Am. Med. Assoc.*, 83; 416, August, 1924.



the supernatural order is concerned. The sign instituted by Christ for this purpose consists in the anointing of the person in danger of death, from sickness or old age, by the priest, who at the same time says the appointed words. The oil used in the sacrament is olive oil which has been especially blessed for use in this sacrament on the previous Holy Thursday by the Bishop. Ordinarily, the priest anoints the "external senses," using the term in the common, rather than the scientific, meaning. He makes the Sign of the Cross with his thumb, which has been dipped into the "oil of the sick," as it is called, on the eyes (lids), ears, nose, mouth, hands, and feet, saying at the same time: "Through this holy anointing, and His most pious mercy, may the Lord forgive whatever you have sinned in." For emergencies and for cases in which the body has been mutilated, briefer forms and modifications are provided for use. Suitable prayers are provided for use preceding and following the actual anointing.

Unlike the Sacrament of Baptism, the Sacrament of Extreme Unction can be administered only by the priest (ordinarily, the parish priest of the place). Its institution by Christ is known from the testimony of St. James the Apostle (Epistle of St. James) and from references to its use in the Christian literature from the earliest Christian centuries. Its effects are the special Sacramental Graces needed or useful for final perseverance, the forgiveness of sin in persons who have at least imperfect contrition and are unable to confess, the increase of Sanctifying Grace, and the restoration of physical health or improvement if God sees fit. Probably every physician and priest has seen



cases in which improvement in the mental state follows the administration of Extreme Unction, probably because of the fact that the patient's anxiety lest he die unprepared to face his Maker is relieved. Admittedly, among faithful Catholics at least, this Sacrament has natural as well as supernatural effects for the good of the patient.

Extreme Unction can and should be received by every Catholic who is in danger of death from sickness, injury or old age. The danger does not have to be proximate, that is to say, immediately impending or very grave. Even the probable danger of death from sickness or old age is sufficient. Physicians therefore should advise their patients to "be anointed" if they are even in remote danger of death. Unfortunately, physicians and relatives and even patients themselves sometimes fear to send for the priest because they do not like to consider the possibility of an early demise. This attitude is hardly consistent with a firm faith in the truth of the Church, and in the usefulness and power of the Sacraments. The priest is commonly called to attend sick persons with the suggestion or warning that the patient not be alarmed, or that he pretend to have dropped in accidentally, or something of that sort. In almost all cases the priest finds that the family has been worrying about alarming the patient and the patient has been worrying about alarming the family, while at the same time everybody has been worried lest the patient die without the Sacraments. It is the duty of any physician certainly to advise the patient or his family of the danger which exists; and if he is a Catholic physician in the meaning of the word which we have given in our earlier chapters, he will be as

much interested in doing whatever he can for the supernatural health as he is in the natural health of his patient, if not more interested.

In cases in which there is doubt as to whether the patient is in danger of death or not, it is well to inform the priest of the circumstances and let him be the judge as to whether the Sacrament should be administered conditionally. If these principles are practiced, the patient will have the benefit of all that it is possible to do for him. In cases of sudden or unexpected death or in the event of the death of a person who has not received the Sacraments, the priest should be called anyway and as soon as possible. He can administer the Sacraments of Penance and Extreme Unction conditionally after apparent death, since, as is now well known, life may still be present. This is demonstrated by the "revival" of apparently dead persons by adrenalin, cardiac massage, artificial respiration, etc.

**Viaticum.** If the patient who is in danger of death is conscious, not nauseated, and able to swallow and retain a small particle of food, he should receive Viaticum before being anointed. In fact, in the ordinary case Extreme Unction is preceded by Confession and Viaticum and followed by the conferring of the Last Blessing. The word "Viaticum" is derived from the Latin word meaning "with thee on the way." Its connotation is "a companion on the way of death." Actually, Viaticum is the Sacrament of Holy Communion received by a person in danger of death. For the benefit of any reader who may not know what Holy Communion is, we will say that when a person receives Communion, he receives Jesus Christ, Body, Blood, Soul

and Divinity, under the appearance of bread. Viaticum may be received without observation of the ordinary fast which is prescribed for healthy persons who receive Holy Communion, that is, abstinence from food or drink from the preceding midnight. All persons in danger of death, if they are able to, are obliged by the Church Law to receive Viaticum.

The Last Blessing, which may follow Extreme Unction, is a special blessing which confers upon the recipient, if he is properly disposed, a Plenary Indulgence which is effective at the moment of death. The conditions for gaining this indulgence are the state of grace, the acceptance of death with resignation to God's will, and the invocation of the name of Jesus, vocally if possible, otherwise "in the heart."

A sick person, whether or not in danger of death, may receive the Sacrament of Penance as frequently as he wishes and the Sacrament of Holy Eucharist as frequently as he wishes up to once a day. If he has been confined with illness for at least a month, with no immediate prospect of being able to attend Church, his confessor may dispense him from the Eucharistic fast as often as once or twice a week to the extent of taking liquids if necessary before he receives Communion. A patient in danger of death who has already received Extreme Unction may receive it again, as often as a new danger of death is added to the danger already existing, as, for example, when a person who has had a cerebral hemorrhage contracts pneumonia. A person suffering from a chronic illness or from old age which places him in danger of death is permitted to receive Ex-



treme Unction as frequently as once a month. When Extreme Unction is repeated in the same individual, the Last Blessing is not repeated, since its effect takes place at the moment of death no matter when it has been conferred.

**Some Remarks about Sick Calls.** The priest visits the sick for a variety of purposes, sometimes merely to give the suffering the comfort of his presence or to recite some of the official prayers of the Church for him; but all Catholics should know what preparations to make when the priest visits the sick to administer the Sacraments. We devote these few lines, therefore, to a description of what should be done in preparation for and during the sick call, for the administration of Extreme Unction or Holy Communion. Incidentally, people who are sick for any length of time and desire to receive the Sacraments of Penance or Holy Eucharist, or both, may do so in their place of sickness. They need merely to make the request to the priest.

**Preparations.** Every Catholic home should be equipped with a standing crucifix, two candlesticks, two wax candles which have been blessed, a white linen cloth which may be of any size but need not be larger than an ordinary napkin, a smaller hand towel, some absorbent cotton, a glass or other receptacle for water, a spoon, and a small holy water container containing holy water. Hospitals, Catholic or non-Catholic, which receive Catholic patients, should be equipped with the same outfit, more than one if possible, since a number of patients are likely to receive Sacraments at the same time. These things should be kept in a convenient place, known to the household, and not stored away in a place difficult of access or easily forgotten.

In preparation for the sacramental sick call, the cloth should be spread on a table or bureau, or something of the sort, in the sickroom, and upon it should be placed the crucifix, the candlesticks with candles, the glass of water and spoon, the cotton (if Extreme Unction is to be administered), and the holy water. There should be space in front of the crucifix in the centre, upon which to place the Pyx (vessel containing the Blessed Sacrament) or the Holy Oils. If the priest is expected to bring the Blessed Sacrament, he should be met at the door of the house by somebody carrying a lighted candle and all the people in the house should be present in the sickroom and should kneel on his entrance, in reverence to Christ in the Blessed Sacrament. They should remain kneeling in prayer for the sick person during the administration of any Sacrament, with the exception of the Sacrament of Penance (Confession). If the Sacrament of Penance is administered, they should leave the room as the priest instructs them, only during the time in which the patient confesses his sins and is absolved, and should return to the room and kneel in prayer for the remainder of the period. Of course, aged, infirm, or other persons unable to kneel may sit.

In all hospitals, provisions should be made for privacy when the priest visits a patient, especially for the administration of the Sacraments or possible advice in matters of conscience. Priests, physicians, and nurses can, and do for the most part, co-operate in the supernatural and natural care of the patient, who, be it always remembered, is an individual person, created to know, love, and serve God and to enjoy eternal happiness with Him.















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